9 September 2006

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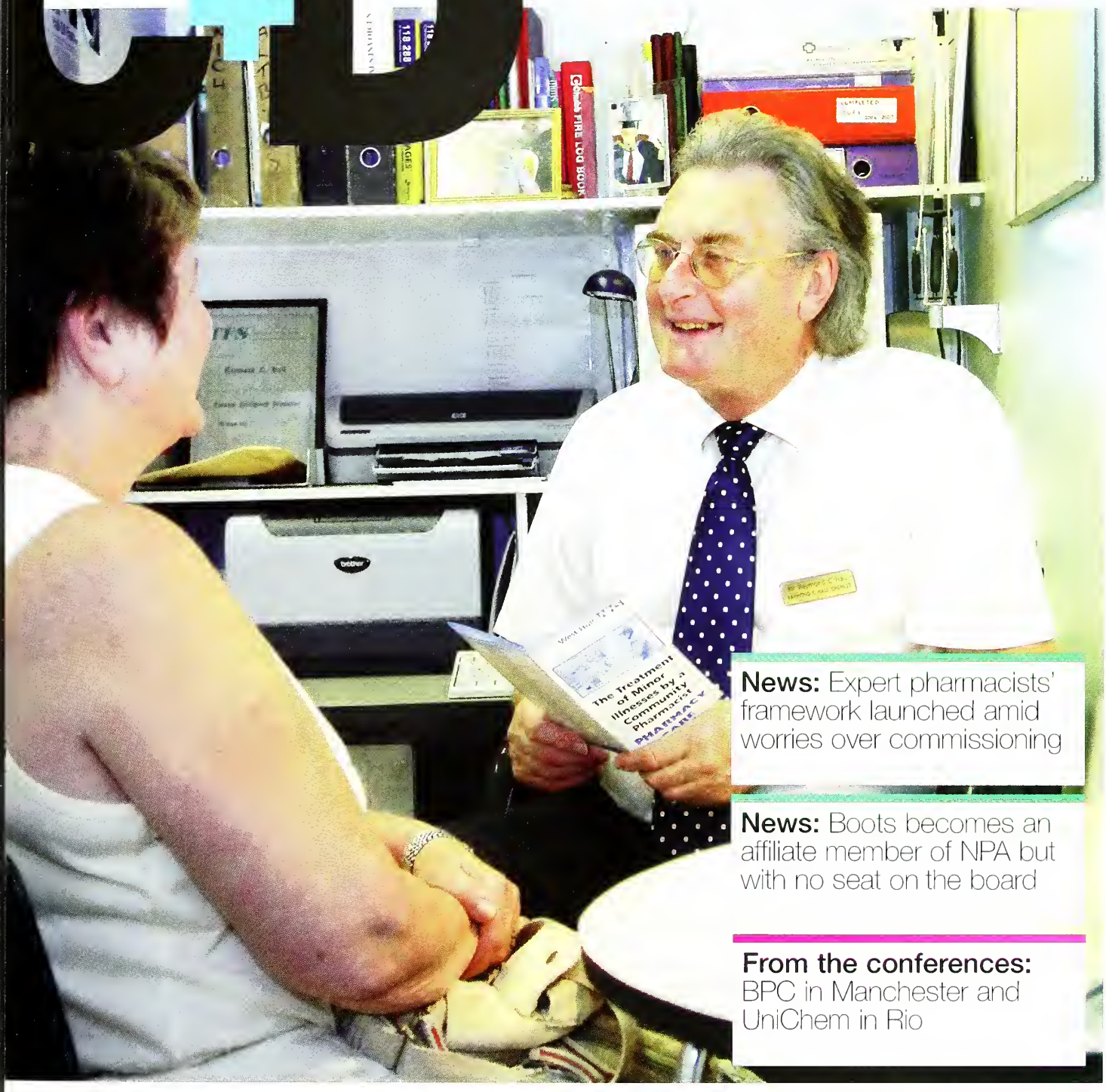

News: Expert pharmacists' framework launched amid worries over commissioning

News: Boots becomes an affiliate member of NPA but with no seat on the board

From the conferences: BPC in Manchester and UniChem in Rio

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C+D

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Cover Raymond Hall, this week's Pharmacy Champion. Picture: UNP

PhwSIs go into the frame

Practice Special interests framework launched

Patrick Grice

A national framework for pharmacists with special interests (PhwSIs) has been launched.

It brings nearer the time when patients with long-term conditions could have their illness managed in the community. Pharmacists will be given the option to become 'experts' in conditions such as diabetes, skin disorders and anti-coagulation drugs. They will have to undergo extra competency based training beyond their core professional role, and become accredited to demonstrate appropriate knowledge and skills.

Health minister Andy Burnham launched the framework at the British Pharmaceutical Conference on Monday. "The framework builds on pharmacy's core roles and allows commissioners an opportunity to maximise pharmacists' contribution in specialist areas," he said. "Easy access – one of pharmacy's core strengths – must be underpinned by quality and safety. The framework sets out a process for supporting accreditation and competency."

The framework is part of the ongoing implementation of 'A vision for pharmacy in the new NHS' and sits alongside the wider development of the pharmacy workforce, including national occupational standards for pharmacy roles, better use of skill mix and the establishment of consultant pharmacist posts.

Although the model will best fit community pharmacists, it does not preclude hospital pharmacists from delivering services in the community. PhwSIs do not need to become independent prescribers, but doing so will clearly enable them to develop new service models that are attractive to patients and service commissioners.

The framework includes a definition, guidance on how services can be put in place, competency frameworks and examples of current service models.

More information at www.primarycarecontracting.nhs.uk/119.php

How to become a pharmacist with special interest

Adrienne de Mont

The first step to becoming a pharmacist with a special interest is to find out from local commissioners whether they intend to commission specific services in this way.

Pharmacists will need to complete the locally determined accreditation process, which should closely follow national guidelines. This will include showing:

- A clear understanding of the role they are being asked to fulfil.
- Appropriate skills and competences to fulfil the new role; these will always exceed the core competences of the individual's normal professional role.
- A commitment to ongoing training, updates and education through appropriate appraisal and their CPD record.

PhwSIs must be able to act without direct supervision, deliver clinical services directly to patients and have a "personal interaction and clinical relationship" with them, according to guidance produced by NHS Primary Care Contracting on behalf of the Department of Health.

The expert pharmacists will be expected to use their professional judgement and work within their professional competence. They will be accountable for and must be able to justify their actions, so must be covered by professional indemnity arrangements. Insurers will require them to describe their scope of practice and premiums may be adjusted to take account of the level of risk involved.

Photo: J Miles/RPSGB

Andy Burnham: giving pharmacists the opportunity to become experts

Practical issues to be resolved during the commissioning process include:

- Ensuring the service is sustainable in terms of staff absence and turnover, so it should not rely on a single practitioner but be part of a wider local service.
- Agreeing fees and remuneration.
- Considering the need for Criminal Records Bureau checks.
- Ensuring that prescribing costs are identified and that there is agreed access to a prescribing budget if appropriate.

Those planning the new service will need to identify the resources necessary and available to support it, and identify the optimal location for its delivery.

The above guidance is published in 'Implementing care closer to home – providing convenient quality care for patients: A national framework for PhwSIs'. Further guidance, including national guidelines for PhwSIs, is expected later this year. More information at ww.primarycarecontracting.nhs.uk

Don't leave us

RPSGB Call for more

Charles Gladwin

Hemant Patel has called on the government to do more to ensure pharmacy is not overlooked in the commissioning of local health services.

The Royal Pharmaceutical Society president has also expressed his concerns about the level of funding and government support for pharmacy services, lack of awareness of pharmacy among primary care trust managers, and changes to the control of entry regulations.

The comments were made in his address to the British Pharmaceutical Conference in Manchester on Monday, attended by the health minister Andy Burnham.

"Pharmacists need to be more included in consultation processes and allowed to be more engaged in the delivery of services," said Mr Patel. While recognising the "enormous vote of confidence inherent in significant new developments", Mr Patel warned: "Neither the RPSGB nor the government should underestimate

Health minister Andy Burnham listens as Hemant Patel tells BPC delegates that pharmacists need government support to deliver their full potential

S60 Order: RPSGB regulatory and leadership split ahead?

Politics Minister hinted S60 will split RPSGB's role

Patrick Grice

Health minister Andy Burnham has hinted that the government intends to split the regulatory and leadership roles of the Royal Pharmaceutical Society.

The Section 60 Order that will "facilitate modernisation of the RPSGB as a regulator" can be expected at the turn of the year, subject to parliamentary agreement, he told the British Pharmaceutical Conference on Monday.

He added: "In July there were two reviews looking at medical and non-medical professional regulation. In considering their recommendations we should bear in mind the appropriateness of the same organisation having responsibility for professional regulation and professional leadership has been called into question."

However, the minister promised the Department would consult extensively in developing new proposals on supervision.

"We cannot embark on reforms that will put patients at risk. But if we are to free up pharmacists to use their clinical skills to greater effect we recognise that we cannot continue as now," he said.

The Health Act 2006 and the provisions that clarify the law and responsibilities of a pharmacist in charge of a pharmacy will bring new requirements, said Mr Burnham.

"There are two key points to make about the responsible pharmacist. First, the general rule is that there will be one responsible pharmacist for each pharmacy (other than in exceptional circumstances). Secondly, while the responsible pharmacist may want to leave the pharmacy, this will be his or her main place of work where they should spend the majority of the working day."

On supervision, the Act will allow the delegation of certain tasks to suitably qualified staff. There will be tasks that remain for the pharmacist alone, for example the clinical assessment of a new prescription. The pharmacist in charge will be responsible for deciding which tasks can be delegated in accordance with the procedures that he or she has set out.

"I appreciate how concerned you are to know the detail of our proposal so following the information paper we published last January we will be working with stakeholders through workshops and other events to develop the detail of our proposal prior to a full consultation on the draft regulations," the minister said.

In brief

Plea to keep joint roles

Mr Patel used his address to reinforce the Society's standing as a professional representative body and a regulator.

The Society is uniquely equipped to succeed in developing the profession's potential, he said. "We regulate for public protection with our eye on the needs of the future. We lead and promote the profession within a culture of accountability and responsibility. We learn from the experience of regulation and leadership and plough that into learning practice."

The Society is working on a change management programme for the profession. "I believe this work clearly demonstrates the connections between our regulatory and leadership roles, because for many of these activities, if you ask 'is it regulation or is it leadership?', you get the same answer," he said.

Control of entry fears

While welcoming recent research about PCTs planning to commission enhanced services, Mr Patel pointed out that there are fears about the exemptions to the control of entry regulations, particularly with regards to the 100-hour pharmacies and those in primary care centres. "A balance needs to be struck between the legitimate desire to create longer opening hours and centralised GP services, and maintaining local access to healthcare, particularly for those who find travelling difficult," he said.

ɔut of commissioning plans

nvolvement in consultation processes

ıe support that pharmacists will eed to deliver their full potential. "Pharmacists will need the ıstained support of government and s commitment to shape healthcare elivery across and beyond aditional boundaries," he added.

NHS financial "difficulties" are ready making an impact: "At PCT vel, this has led to some reductions the pharmacy service and even ɔme job cuts. The fact that some ɔn-executive directors have little nderstanding of pharmacy is ɔmething that the profession will eed to address, to ensure that ck of knowledge does not anslate into a deprioritisation of harmacy issues."

Mr Patel called on the minister to se the reconfiguration of PCTs in ngland as an opportunity to learn om the progress that has been ıade in Wales and Scotland. "To e properly effective, the ɔmmissioning of NHS services has ɔ be informed by strategic harmaceutical advice and medicines ıanagement expertise," he said.

Harking back to former health secretary Alan Milburn's view of pharmacists as "clinicians, not shopkeepers", Mr Patel said that "clinicians would have a role in commissioning primary care, they would have access to the local NHS IT infrastructure, and they would be able to provide strategic pharmaceutical advice.

"The involvement of pharmacists in local commissioning can only be of benefit ... commissioning must be inclusive and reflect the contribution of the whole healthcare team."

While there are some obstacles, he was confident that these "...can be overcome if commissioning is truly inclusive, robust and focused on the interest of the local population".

However, pharmacy needs more local influence, as there is evidence and commentary from pharmacists working in primary care that they are not being heard by many trusts. He also criticised the lack of consistency in the NHS approach to primary care. "The frustration is that each time we get near enough to the goal to shoot, the goal posts move. This makes it very difficult to score a goal."

Boots joins the NPA

Multiples NPA 'delighted' with affiliate membership announcement

Charles Gladwin

Boots The Chemists is joining the National Pharmacy Association.

The NPA was "delighted" to make the announcement, saying: "It has been the NPA's declared intent for a number of years to bring all pharmacies into membership."

The Boots Company has recently merged with Alliance-UniChem, but its two pharmacy businesses – Boots The Chemists and Alliance Pharmacy – have yet to be brought together and are operating separately. Alliance Pharmacy has been a member of the NPA for many years and has a co-opted seat on the NPA board. Boots will join as an affiliate member, without a seat on the board.

Supporting its announcement, the NPA said that "it is essential that pharmacy acts and is seen to act cohesively in getting a united message across to government and other key stakeholders on the ways it can embrace change and integrate itself into wider healthcare planning.

"What is needed is unity among pharmacy. This will not be measured by the number of bodies purporting to represent the sector but by the collectiveness of the message.

"Boots's decision to join the NPA illustrates a commitment to a cohesive community pharmacy sector and sends out a strong message of a strong community pharmacy sector."

Boots The Chemists has been the key force within the Company Chemists' Association. The CCA said: "Like the vast majority of the CCA's member companies, Boots has clearly recognised the benefits at both store and head office level that access to the high quality support services that the NPA provides will bring."

The news was announced at the UniChem Convention in Rio. UniChem chief executive David Coles said that Boots joining the NPA "became an agenda item early on" in the merger discussions between Boots and Alliance UniChem.

NPA chief executive John D'Arcy said that the merger had accelerated discussions with Boots and brought membership into focus.

Reaction to the announcement

Martin Bennett, former NPA board member :
"This means that the NPA will be speaking to the whole of community pharmacy, which has to be good. I suspect that many independents will feel that their voice has been weakened but overall pharmacists do need to see the bigger picture.

"People will take more note if the NPA can say that it represents all of community pharmacy. Hopefully, it will also mean we all start co-operating."

CCA chief executive Colin Baldwin:
"The CCA will continue to work for a strong, professional, profitable and sustainable pharmacy market and to represent the particular interests of its members – the major multiple pharmacy businesses in the UK. The CCA has always maintained close links and enjoyed a constructive working relationship with the NPA."

Minister calls for enhanced services

Politics Andy Burnham wants to 'deliver the vision'

The health minister wants to see more commissioning of enhanced services. Addressing the British Pharmaceutical Conference on Monday, Andy Burnham commented: "Some may say the Department has not delivered all that it promised, and that the take-up of enhanced services needs to improve. I am ready to continue that dialogue because we want to achieve precisely those things. Let us work together to ensure we unblock the blockages and deliver the vision."

He said he was encouraged by recently published research that indicates PCTs will be commissioning further enhanced services from community pharmacy over the coming 12 months, such as minor ailment schemes, anti-coagulant monitoring and medicines management. "I want to see more of it. I think it is still early days. It is the right way to go. At a departmental level I would like to see the dialogue at PCT and SHA level so that these welcome trends continue." **PG**

C+D presents Practice Award

People Award recognises research into healthcare

Patrick Grice (left), representing C+D, presents Rob Horne with the C+D sponsored BPC Practice Research Award medal and a cheque for £1,000

Photo J Miles/RPSCB

Professor Rob Horne has been presented with this year's BPC Practice Award medal, sponsored by Chemist + Druggist.

The award recognises his research on making healthcare more efficient by understanding and addressing the psychological and behavioural factors explaining individuals' responses to medical treatment.

Professor Horne has just taken up the post of professor of behavioural medicine at The School of Pharmacy, University of London, but was previously based at the University of Brighton.

He was presented on Wednesday with the medal and a cheque for £1,000 by Patrick Grice, projects manager for C+D. An article about Professor Horne's work appears on p44-45. **CRG**

New contract costs hit PSNC

PSNC EPS preparation takes toll on operating surplus

Almost half of last year's operating surplus has been spent on implementing the new contract and preparing for the electronic prescription service, PSNC's annual report for 2005-06 reveals.

The negotiating body reported an after tax surplus of £20,884 at its year-end in March, a figure almost 49 per cent down on 2005. Over the past 12 months, staff and employment plus communication costs have proved the major drain on PSNC finances: over the year staff and employment costs jumped 21.1 per cent to £1.56 million, while communication costs almost doubled (up 91 per cent) to £245,189.

According to Mike Dent, PSNC's head of finance, implementing the new contract has required significant expenditure on support staff and other costs relating to developing a checking function suitable for use in the EPS. It has also necessitated a high spend on communications. Employment costs also include pension costs, which increased 35 per cent to £376,762, reflecting a one-off payment to help reduce levels of under funding, he notes.

The annual report also points out that PSNC has been active in promoting the profession, shaping policy and supporting LPCs. PSNC chairman Barry Andrews commented: "For many, embracing the new contract was not easy." **AC**

Top up payments

In response to queries, PSNC points out that an establishment payment top up is only likely to be required where monthly dispensing volumes fluctuate between the payment bands and where contractors have dispensed fewer than 2,500 prescription items during one or more months of the year.

To claim a practice payment top up, contractors need to have dispensed fewer than 2,000 prescription items during one or more months of the year.

PSNC advises that claims should be submitted by November 30, and template PCT claim letters are available from www.psnc.org.uk

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LPC produces medicines use review resource pack

Practice Resource pack has all information accredited contractors need

Ailsa Colquhoun

Hampshire & Isle of Wight Pharmaceutical Committee has produced a new medicines use review resource pack and GP briefing document, as part of its ongoing MUR strategy.

The resource pack aims to give accredited contractors the skills and confidence to deliver MURs, and contains hints and tips on recruiting patients as well as guidance on workflow. The pack also contains:

- A medicines use review overview (what it is and is not, what it involves, benefits).
- MUR process flowchart.
- Case studies.
- MUR delivery workflow.

The document, which is a joint collaboration between the LPC, the Pharmacy Collaborative team and with input from CPPE and multidisciplinary group working, is being supported by a series of MUR skills workshops, designed to build on accreditation. These are running in the LPC area between September 14 and November 9. The LPC, in a joint initiative with the local medical committee, has also sent out a GP briefing letter. LPC chief officer Mike Holden, explains: "A lot of the problems with MUR delivery lie with us as a profession not communicating with GPs, as well as a lack of understanding at their end.

"MURS are also a good opportunity to open effective two-way communication channels and joined-up patient care, which can be built into the enhanced services of the future. This document aims to create a more level playing field."

LPC unveils its ideal MUR form

Hampshire & IOW LPC has proposed and sent to the Department of Health its vision of how an MUR form should look.

Its form, a simplified version of the existing MUR form, comprises two sides of A4. The first side clearly details the action points for the patient, pharmacist and GP; the reverse contains additional background information.

According to Mr Holden, the DH is currently considering the form, and the hope is that it will be incorporated into the revised MUR form due to be published before the end of the year.

"One of the barriers to MUR delivery is that the existing form does not match what we are supposed to be doing in an MUR, which is frustrating GPs, pharmacists and patients. The current form is too big, there is too much duplication of information and some information is irrelevant."

Minor ailments service opens to homeless

Practice North West pilots scheme to cut homeless visits to GPs and A&Es

Homeless people are being given free access to a minor ailment service in a pilot scheme being rolled out in the North West.

The Pharmacy First project, devised by Blackburn with Darwen PCT, has been opened up to improve the health of the region's homeless population while cutting down on unnecessary visits to GPs and A&E departments.

The extended formulary of medicines, which includes treatments for ailments such as allergies, cold and flu symptoms, head lice and indigestion, is distributed free to the homeless as well as those who do not pay for prescriptions.

Access to the scheme was prompted by research from the Housing Needs Team within Blackburn with Darwen Borough Council. It found that despite 80 per cent of homeless people being GP-registered, very few were accessing primary care services because they were unable to travel. As a result minor ailments were developing into more serious conditions.

Launching the minor ailments scheme at Bramwell House are, from the left: Jason Horsfield, principal project worker, Bramwell House Salvation Army Hostel, Blackburn; Anna Atkinson, community pharmacy facilitator, Blackburn with Darwen PCT; Lyn Bentley, PCT medicines management services manager, and Laura Strickland, homeless programme and project officer, Blackburn with Darwen Borough Council

Pharmacists were found to provide more flexible access without the need for booking an appointment. A total of 23 out of 34 pharmacies and a third of all GPs within the PCT are now participating.

Pharmacy First was trialled at Bramwell House, a Salvation Army hostel in Blackburn. Staff at the centre issue homeless people with medicines, pass books and details of participating pharmacies.

Neighbouring Burnley PCT has already expressed interest in the scheme and Anna Atkinson, PCT community pharmacy facilitator, says it has national appeal. "Potentially, we can help other PCTs so hopefully, if we get good results back, it's good for other PCTs," she said. **TH**

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Pharmacists launch birth control pilot scheme

Practice Six month project targeted at women aged 25 and under

Tom Hawkins

Free pregnancy tests and condoms are being handed out by pharmacists as part of a pilot scheme to reduce unwanted pregnancies.

Five pharmacies within the Cotswold and Vale PCT region are taking part in the project targeted at women aged 25 and under. It began in mid August and will run for six months.

As well as free tests and contraceptives, the accredited pharmacies will provide a confidential consultation service and onward referral to advisory bodies, including options within primary care.

Sue Reeve, primary care support manager at Cotswold and Vale PCT, said the trust intended to commission the birth control project as a local enhanced service when there was sufficient funding available. The pilot is entirely supported by the pharmacies.

"We're a cash-strapped PCT so there was no funding for the pilot so we've relied totally on the goodwill of the five pharmacies involved," said Ms Reeve.

One pharmacist involved in the service said: "We are delighted to be a part of this innovative scheme. It fits perfectly into our role as suppliers of EHC. We are here to help and offer assistance when most needed for the benefit of our society."

Pharmacists can improve prescribing, say experts

Education Teaching methods can be honed

Britain's leading pharmacology experts have given their support to calls for pharmacists to be more involved in training medical students on prescribing.

The British Pharmacological Society's president elect, Jeffrey Aronson, along with other senior BPS members, said partnerships with prescribers such as pharmacists would be useful to improve existing teaching methods.

The comments were made in an article published in the British Medical Journal and follow remarks from RPSGB director David Pruce that the NHS is failing to make use of pharmacists' prescribing skills in the training of undergraduates and junior doctors (C+D, September 2, p6).

The BPS has developed a syllabus for prescribing that it says should be adopted by medical schools to ensure students have a sufficient understanding of drug therapies.

"Modern medicines are too potent for the newly qualified graduate to be allowed to prescribe without providing evidence of competence," the authors said. **TH**

Health centre pharmacy opens

Multiples Fun day opened by local mayoress

Councillor John Fletcher is seen with, from the left, the mayoress Councillor Suzanne Fletcher, pharmacy manager Leigh-Anne Carruthers, staff members Sarah Tuffin, Ana Belmonte, Debbie Dale and Gemma Allcock, and Rowland the owl

Rowlands Pharmacy marked the recent launch of its Stockton-on-Tees health centre pharmacy with a fun day for customers and children. The local mayoress, who handed out the day's prizes, also heard how local Rowlands pharmacies recently raised £175 for the NSPCC. **AC**

Guide offers FP34 advice

Contract Common queries are explained

Pharmacy funding specialist Pharmacy Partners has compiled a free guide to FP34 statements and payments for contractors.

The advisory document explains the various terms on the statement and contains a PPD documentation and payment timetable as well as a section on common queries.

It also features seven monthly checks designed to ensure payments are in line with work carried out.

Mahesh Amin of Calder Chemists, Notting Hill, said: "The FP34 statements we receive contain a large amount of really important information and the Pharmacy Partners guide provides a simple explanation of the figures given." **TH**

Citronella insect repellents banned

Legislation Claims can no longer be made

Insect repellents containing citronella or eucalyptus oil as an active ingredient are being withdrawn following changes to EU regulations. The Biocidal Products Directive 98/8/EC came into force in May 2000 and the latest update, which includes citronella, is effective from September 1.

Citronella and eucalyptus oil are still available, providing they are not intended to be used for biocidal or repellent purposes, but insect sprays as well as citronella candles for repelling insects fall under the ban. Products where the primary purpose is cosmetic are not affected, and nor does the ban apply to citradiol.

A Health and Safety Executive spokesman said there was no definitive list of all the individual products affected. As many of the products are not controlled under any existing national regulations the HSE does not hold details of them, but he said that the local weights and measures authority (usually Trading Standards) are the enforcement authority for the sale of products in the UK.

Chemicals which have been 'notified' to the regulators can remain on the market until a review has been completed if manufacturers wanted to continue selling the product. But as the industry did not ask for citronella to be considered, it is now being banned in repellents. Eucalyptus globulus extract and eucalyptus oil are also affected by the September 1 deadline.

"DEET, on the other hand, is being supported by industry so insect repellent products containing it can remain on the market until the review has been completed, at which point the products will require authorisation under the Directive," said the HSE spokesman.

"During the review of DEET, existing national rules continue to apply, so for repellent products for use on animals an approval under the UK Control of Pesticides Regulations would be required before products could be placed on the market." **LAR**

See page 40 for coverage of the BPC in Manchester

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paracetamol & phenylephrine

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Benylin Cold & Flu Max Strength Capsules product information: Presentation: Capsule containing 500mg Paracetamol and 6.1mg Phenylephrine hydrochloride and 25mg Caffeine. **Uses:** For the relief of symptoms associated with the common cold and influenza, including relief of aches and pains, sore throat, headache, fatigue and drowsiness, nasal congestion and lowering of temperature. **Dosage:** Adults and children over 12 years: 2 capsules to be swallowed whole with water every 4 hours, up to a maximum of 8 capsules in 24 hours. Children 6-12 years: 1 capsule every 4 hours, up to a maximum of 4 capsules in 24 hours. Children under 6 years: not recommended. **Contraindications:** Hypersensitivity to any of the ingredients. Severe coronary heart disease and cardiovascular disorders, hypertension, hyperthyroidism, history of peptic ulcer. Also contraindicated in patients currently receiving or within two weeks of stopping therapy with monoamine oxidase inhibitors. **Precautions:** Caution in severe renal or severe hepatic impairment, Raynaud's phenomenon and diabetes mellitus. Concomitant use of other products containing paracetamol. **Interactions:** The speed of absorption of paracetamol may be increased by metoclopramide or domperidone and absorption reduced by cholestyramine. The anticoagulant effect of warfarin and other coumarins may be enhanced by prolonged regular daily use of paracetamol with an increased risk of bleeding. Phenylephrine may adversely interact with other sympathomimetics, vasodilators, and β- blockers. Drugs which induce hepatic microsomal enzymes, such as alcohol, barbiturates, monoamine oxidase inhibitors and tricyclic antidepressants, may increase the hepatotoxicity of paracetamol, particularly after overdosage. **Pregnancy and lactation:** Consult doctor before use. **Side effects:** Hypersensitivity reactions including skin rash may occur. Blood dyscrasias, raised blood pressure, headache, nausea, vomiting and occasionally palpitations; tachycardia or reflex bradycardia; tingling and coolness of the skin, insomnia, restlessness, tremor, anxiety, urinary retention and hallucinations. Rarely reports of allergic reactions. **RRP:** 16 capsules £2.99. **Legal category:** GSL. **PL Holder:** Wrafton Laboratories Limited, Braunton, North Devon, EX33 2DL. **PL Number:** 12063/0066. **Date of preparation:** June 2006. **Benylin Cold and Flu Max Strength Sachets (Non-Drowsy) product information: Presentation:** Yellow powder for oral suspension containing 1000mg Paracetamol and 12.2mg Phenylephrine hydrochloride. **Uses:** For relief of symptoms of colds and influenza, including the relief of headaches, aches and pains, sore throat, nasal congestion and lowering of temperature. **Dosage:** Adults and children over 12 years: Contents of one sachet dissolved in hot water. May be repeated after 4 – 6 hours. Maximum of 4 sachets in 24 hours. Under 12 years: not recommended. **Contraindications:** Known hypersensitivity to any ingredients. Severe coronary heart disease or hypertension. **Precautions:** Caution in severe renal or severe hepatic impairment, Raynaud's phenomenon, [illegible] phenylketonuria. Concomitant use of other products containing paracetamol. **Interactions:** The speed of absorption of paracetamol may be increased by metoclopramide or domperidone and absorption reduced by cholestyramine. The anticoagulant effect of warfarin and other coumarins may be enhanced by prolonged regular daily use of paracetamol with an increased risk of bleeding. Phenylephrine may adversely interact with other sympathomimetics, vasodilators, and β-blockers. Drugs which induce hepatic microsomal enzymes, such as alcohol, barbiturates, monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressants, may increase the hepatotoxicity of paracetamol, particularly after overdosage. Contraindicated for patients currently receiving or within two weeks of stopping therapy with MAOIs. **Pregnancy and lactation:** Consult doctor before use. **Side effects:** Hypersensitivity reactions including skin rash may occur. Blood dyscrasias, raised blood pressure, tachycardia and occasionally palpitations; tachycardia or reflex bradycardia; tingling and coolness of the skin, insomnia, restlessness, tremor, anxiety, urinary retention and hallucinations. **RRP:** [illegible] **Legal category:** GSL. **PL Holder:** Wrafton Laboratories Limited, Braunton, North Devon, EX33 2DL. **PL Number:** 12063/0 [illegible] **Date of preparation:** June 2006.

Reference: 1. Data on file, Pfizer Consumer [illegible] PD's Design Research, Feb 2004. The Big Picture.

Connecting report 'diluted'

IT Board game will address lack of IT trainers

Tom Hawkins

A report containing criticism of the government's project to overhaul the NHS IT system was edited before being published.

An early draft of the document, produced by the National Audit Office, was obtained by the BBC and revealed several omissions from the version finally released in June.

BBC Radio 4's World at One programme claimed that the edited version removed passages that outlined concerns over the slow roll-out of the NpfIT programme and a lack of engagement with healthcare professionals.

The NAO said the amendments did not alter the report's findings. It added that approval by government departments was normal and that it was done in the interest of accuracy.

The BBC also said the initial version of the report included comments that the NHS "lacks the sufficient skills" to deliver the programme and that there are "insufficient trainers to train NHS staff".

Connecting for Health, which is controlling the project, has attempted to address this issue by developing a board game, which is used to raise awareness and stimulate engagement in the new system.

Produced by Focus Games Ltd, Table-Top Challenge is played by two teams of up to six people for around an hour. A facilitator, trained at a free half-day session, oversees discussions on more than 40 NPfIT scenarios and provides feedback to CFH via a special interest group.

The game has been tested with over 350 staff from a range of medical backgrounds. Maria Scott, clinical benefits advisor for NHS CFH, said participants were much more responsive than when faced with communication tools such as PowerPoint. "We are confident that the net result of using the TTC will provide a worthwhile return on investment," said a CFH spokesperson.

Supermarket pharmacies gain ground on OTCs

Retailing Supermarkets made 38.3 per cent of all OTC medicine sales in 2005

Ailsa Colquhoun

Supermarket pharmacies are gaining share in the OTC market, according to new figures from PAGB.

In 2005, supermarket pharmacies reported their second consecutive annual share gain in OTC medicines, the data supplied by IRI shows. In 2005, they sold 38.3 per cent of all OTC medicines, compared to 37.4 per cent in 2004 and 36.7 per cent in 2003. Furthermore, IMS Pharmatrend reports grocers are outperforming pharmacy in both P and GSL medicines, grocers with pharmacies reporting 1.7 per cent growth in P and 3.3 per cent growth in GSL medicines, compared to -5.8 per cent (P) and -6.6 per cent (GSL) in independent pharmacy (MAT March 06 vs Mar 05).

In its latest annual review, PAGB notes independent pharmacists and mail order are more popular with the older groups, while the younger population groups favour Boots. Fifty four per cent of people claim that they have asked their pharmacist for general health advice.

The PAGB review for 2006 goes on to say that pharmacists are already recognised in self-care policies and that through their contracts are ideally placed in the community to support people's self-care behaviour. "But this must be promoted to patients and the public and pharmacists must be seen to respond," a spokesman said.

Congress covers global impact of pharmacy

Overseas Pharmacists from 89 countries give international presence to Congress

The 66th World Congress of Pharmacy and Pharmaceutical Sciences in Salvador, Brazil, last week focused on the growing impact that pharmacists are making on global healthcare.

Opened by Dr Agenor Álvares, who is both minister of health and a pharmacist, the congress brought together over 2,100 participants from 89 countries. In his last address as FIP president, French pharmacist Jean Parrot reviewed the successes of the organisation over the last four years and looked to its future expansion into even more countries.

The former chief scientist of the Royal Pharmaceutical Society, Professor Tony Moffat, was among the recipients of the 2006 FIP Fellowships, established in 2004 to recognise individual members who have shown strong international leadership or distinguishing work in pharmaceutical science or practice.

Professor Tony Moffat, left, who received an FIP Fellowship, RPSGB president Hemant Patel, centre, and Howard Rice from Israel at the welcome party. Photo: Steven Kayne

One group of presentations dealt with country-specific approaches to pharmacoepidemiology and pharmacoeconomics and how new drugs were accepted for reimbursement under national health systems. **SK**

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nicorette® UK's best selling NRT brand
nicotine

Prescribing information can be found on adjacent page.

FDA blames online pharmacy for fakes

Online US FDA points finger at Canadian online pharmacies selling counterfeit drugs

Ailsa Colquhoun

US drug officials have accused 10 Canadian online pharmacies of selling counterfeit versions of drugs including Lipitor, Crestor, Celebrex, Diovan and Propecia.

In a new report, the US Food and Drug Administration says that prescriptions filled by two Canadian pharmacies have been found to contain lower concentrations of the active ingredients than in genuine products.

The pharmacies, Mediplan Prescription Plus Pharmacy and Mediplan Global Health in Manitoba, Canada, are also understood to supply drugs to the UK.

However, supporters of Canadian online pharmacies say the FDA has a long-standing opposition to the trade, which supplies branded products to un- or under-insured patients living in North America.

"It has a pattern of trying to instil fear in the US public about legitimate Canadian drugs, consultant David MacKay told CNews, a Canadian online news service.

Opponents to the trade, which has been valued at about $1 billion, say it could allow counterfeit drugs to enter the supply chain.

Direct supply may be entry point for fakes

The European wholesalers' trade body has warned that manufacturers who directly supply pharmacies create new grey market opportunities, and could increase the chances of fake medicines entering the market.

In a letter to Jeffrey Kindler, Pfizer's newly-appointed CEO, GIRP president Rene Jenny says that wholesalers are committed to ensuring the safety and continuity of the medicines they supply. "Alternative distribution options irresponsibly place the health and wellbeing of European citizens in unwarranted danger, and will also result in chronic shortages of vital products," he said.

NHS to curb ineffective treatments

Policy Calls on Nice to help identify failing treatments

Ineffective treatments are to be targeted in a programme to help contain NHS costs. The National Institute for Health and Clinical Excellence will help identify treatments that do not improve patient care or do not represent good value for money. It will look at three areas: technology appraisals and guidelines aimed at reducing ineffective practice; recommendation reminders; and commissioning guides.

Nice chief executive Andrew Dillon said that as Nice already advises the NHS on when it should invest in new drugs and treatments, "it's common sense for us to also advise the NHS on when it is appropriate to stop using treatments that don't benefit patients or do not represent good value for money.

"I would like to encourage anyone who has suggestions for topics that Nice should consider to let us know." More information can be found at www.nice.org.uk **CRG**

News in brief

AAH online

AAH Pharmaceuticals has posted proceedings and pictures from its annual convention, which was held in Athens in June (C+D, June 10, June 17), on its website. Go to www.aah.com/convention/aah_convention_main.asp

Merck reprieved in Vioxx battle

ledicines 'Excessive' compensation claim against Merck overturned by US judge

om Hakwins

erck has been given a financial prieve in the legal battle raging ver withdrawn painkiller Vioxx after judge overturned a £27 million mpensation claim.

US District Court Judge Eldon llon ordered a new trial to reassess e damages that were awarded to rmer FBI officer Gerald Barnett by a federal court in New Orleans on August 17.

The written ruling reportedly described the amount as "excessive under any conceivable substantive standard of excessiveness". Merck is requesting that the new trial should revisit the basis of the liability claim regarding Vioxx's safety.

Phil Beck of Bartlit Beck, Merck's outside counsel, said: "Whatever the scope of the new trial, we look forward to presenting our evidence to the jury."

Mr Barnett's claim was brought after he suffered a heart attack in 2002 aged 58. He took Vioxx for 33 months.

News of the ruling coincided with the dismissal of two class action claims filed in the federal court by plaintiffs from France and Italy. The court ruled in favour of Merck's argument that it was more appropriate for the cases to be tried within the claimants' native judicial systems.

British Vioxx users are among up to 300 injury claims from non-US citizens that have been filed with a court in New Jersey. A decision is expected imminently on whether the cases can be heard in the USA.

Claims for homoeopathic medicines

ledicines New rules allow ome remedies to specify use

ne Medicines and Healthcare oducts Regulatory Agency (MHRA) st week introduced new rules to low homoeopathic medicines to ecify on the label the symptoms they n relieve although this is limited to inor ailments such as colds, coughs d hayfever.

Under the voluntary scheme, omoeopathic products will receive a ence if they can provide bibliographic idence of traditional use.

Homoeopathic medicines on the arket before 1968 were given product ences of right (PLR), which allowed em to make claims about health nefits.

Once the UK entered the EU no new oducts were licensed, because of a lack of ientific evidence of efficacy.

An abbreviated scheme for the ensing of homoeopathic medicinal oducts, specified by European irective 2001/83/EC, was based solely n quality and safety. Members of the blic had to consult leaflets or seek advice om the seller as to the use of the edicines on sale.

The British Homoeopathic Association nd the Faculty of Homoeopathy have elcome the long-anticipated move. owever, critics argue that the edicines will not be rigorously tested they do not need to undergo the nical trials orthodox drugs do to get licence.

Homoeopathic medicines have recently een included in the new Veterinary egulations and the first licence for arnica r animal use has been granted. **SK**

Coverage of the UniChem Convention starts on page 50

United Co-op chief is taking acquisitive group to new heights

Retailing General manager John Nuttall tells C+D about his plans to create a pharmacy giant

Max Gosney

John Nuttall takes a break from business at United Co-op to ponder the exotic selection of biscuits just delivered to his Stoke-on-Trent-based office.

Casting his eye over the custard creams, chocolate chip cookies and bourbons, he reflects on a time of rich pickings for the company's pharmacy business. "Healthcare is a boom area for United Co-op at the moment and is receiving a large amount of investment. We're looking to add around 40 pharmacies a year and plan to reach the 300 mark by 2007," he says.

The recent acquisition of the 54-strong P Williams pharmacy group took United Co-op's tally of stores to 230. The group's three-year growth spurt, during which it has almost doubled in size since forming in 2003, has created challenges to drug supply, says Mr Nuttall. "We supply the stores through our integrated Sants wholesale business. But as the group expands it's difficult to keep up high services levels with only one warehouse. We've got plans to look to set up a second site or form a strategic partnership."

Sants' Stoke-on-Trent site supplies a portfolio of United Co-op pharmacies stretching from Scotland to Stratford, explains Mr Nuttall. The group has its eye on adding more pharmacies within the area, adds the Co-op chief. "We've got a few things we're working on at the moment," he reveals. "It's more cost effective to acquire a group of pharmacies. But it's also important to consider location and whether the pharmacy is near a GP or health centre."

The P Williams group, with an annual turnover of £50 million, ticked the right boxes for a buyer, says Mr Nuttall. "It's a business that we've been interested in for a long time. It's very popular with customers and has a strong brand."

P Williams's customer appeal is appreciated by United Co-op, stresses Mr Nuttall. "There are no immediate plans to rebrand the sites and we may decide to keep some under the P Williams name." United Co-op's bid to maintain the status quo includes retaining around 600 P Williams staff, says Mr Nuttall. However, it has closed the firm's headquarters and World of Babies store in Nantwich this summer as part of plans to "drive value" from the business.

John Nuttall: a time of rich pickings for United Co-op's pharmacy business

But the group's future revenue won't be based on bricks and mortar pharmacies alone, Mr Nuttall reveals. "It will be interesting to see how the market develops when you get phase two of the electronic prescription service. Allowing patients to nominate a pharmacy to pick up their prescription will open the door up to online pharmacies," he says.

United Co-op has grand plans for the electronic age after being granted an internet contract under control of entry regulations this summer, he explains. "We're looking to set up an automated central dispensary at Sants, which would deal with repeat prescriptions. The next phase would be to extend to a full internet offer alongside the rollout of EPS."

Despite securing a contract under control of entry, United Co-op is cautious over current regulations, says Mr Nuttall. "I think the 100-hour exemption is being used in a way that was not intended. Many of the big operators are using it as a threat against pharmacists in the area by saying 'If you don't sell us your business we'll open a 100-hour pharmacy'," he says. Yet, despite the difficulties, it would be unwise for the Department of Health to alter the current control of entry rules too soon, concludes Mr Nuttall.

"It would be a mistake to change the system again now. I'd like to see the DH's planning structured so we have a greater opportunity to plan and invest. Everything seems to have come at once for pharmacy."

John Nuttall on:

EPS:
"We've been a bit frustrated by the time it has taken to get where we are now."

A merger:
"We are committed to our Co-operative values and would not be in a position to give those up."

MURs:
"Within United Co-op we've seen a slow start, but we're looking to up the pace now."

The future:
"Pharmacy will become more involved in providing healthcare services and it's important that happens."

Staff:
"I think the British labour market is tight. There's a potential situation for a shortage of pharmacists."

His high point:
"Successfully integrating the wholesale business and rapidly growing the business in a short space of time."

United Co-op is looking to take its number of pharmacies to around 300 by next year

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Comment from the editor

With one voice: will pharmacy's message get through, now?

The announcement that Boots The Chemists is to become a member of the National Pharmacy Association will, no doubt, be of significant interest to the fledgling Independent Pharmacy Federation.

One of the reasons the NPA was established back in the early part of last century was to represent the independents' voice when Boots was by far the largest multiple. For the NPA to now have Boots as a member, albeit as an affiliate and without a seat on the board, demonstrates how the nature of community pharmacy has changed. For the IPF, the news may boost its cause, but it is more likely that independent contractors will continue to belong to the NPA because of the extensive range of support services it offers. For the IPF to become anything other than a lobbying group, it will have to provide a similar range of support to succeed.

So what is in it for Boots? The newly merged Alliance Boots has yet to set out in public what will happen to the two pharmacy businesses it operates in the UK, but as Boots has managed quite well for many years without being an NPA member, it is difficult to see what the NPA can provide that it does not already do.

No, the real benefit, and what is needed at a time when the health professions are under scrutiny, is to have one strong voice representing the whole of community pharmacy. The doctors have benefited from having the BMA, but then again, doctors tend to work as individuals or partners – there isn't a single contractor/massive multiple divide like pharmacy.

Pharmacy, with its many different representational bodies, has for too long been criticised for not going to the ministers with a single voice. Having Boots as an NPA member means the NPA can say it represents the whole of community pharmacy – give or take a few independents.

Well, that's the theory, but the interests of independents and the multiples can be very different and the NPA will have a difficult task ahead. How can it represent all the diverse views its members hold?

Take control of entry, for example, where its supermarket members are the ones making the most of the 100 hour exemption criteria. What about remote supervision? And the specific case of the NHS chlamydia screening service that the Department of Health allowed in Boots's London stores but with no other pharmacy contractors permitted to take part?

It's one thing to have collective views but another to come to a single conclusion that it can argue the case for. But these quibbles are a distraction, because the NPA will argue that it has been balancing these arguments for years, anyway, without Boots as a member.

What is more important is that the renewed vigour with which the NPA can claim to represent the whole of community pharmacy is not then diluted by agencies like the CCA, AIMp and even the IPF failing to back what is best for community pharmacy as a whole. This is not to say that they do, and especially since the fight to retain resale price maintenance, the various organisations have shown that they can pull together when it matters.

The main task, then, is for the NPA to demonstrate to the outside world that it really does have that mandate to represent community pharmacy.

> The interests of independents and the multiples can be very different and the NPA will have a difficult task ahead

Getting value for money requires some funding

This year's British Pharmaceutical Conference benefited by having the ministerial address on the opening day. In recent years, having to wait until halfway through the last day meant that much of what was discussed was tempered by anticipating what would, or more likely would not, be included in the minister's speech.

Fortunately, the minister did have something to say, which was even picked up by the national media: that 'expert pharmacists' will be encouraged within the NHS. These pharmacists with a special interest (yet another acronym to become familiar with) will have an important role to play, particularly in the management of people with long-term conditions, but also for acute diseases, such as sexually transmitted infections.

It's a shame that doctors had to rain on the pharmacy parade by saying that they hoped patients wouldn't get confused about which health professional provides what. But that is a rather protectionist view, as the public wants the best service, and is no longer willing to see the traditional demarcations between doctors, pharmacists and nurses.

The announcement on PhwSI is good news for public health and will be a professionally satisfying career path for pharmacists. But as commissioning will be done locally, it is essential that the government makes funding available for this, not just at launch, but on a continued basis. If not, the expenditure that goes into training pharmacists will be squandered.

Two days after announcing the PhwSI framework, the minister asked Nice to look at ineffective treatments and weed them out of the NHS. Both initiatives are further signs that health policy is looking beyond simply having some winning headlines at election time. It seems this is actually doing something about addressing the long-term resource needs and anticipating the future health of the population.

It is interesting then, that last week the medicines regulator, the MHRA, changed the rules regarding homoeopathic remedies, which will now be able to carry ostensibly medicinal claims. This time the doctors were right to say it will cause problems and confuse patients, who will assume that anything making a claim will have had the same rigorous testing.

How long will it be before Nice has to tackle the issue of what some regard as 18th Century quackery, but which for others is a valuable contribution to healthcare? It might mean that some of the older OTC products could also be up for scrutiny, although the blacklist in the Drug Tariff has attempted to address efficacy since the 1980s.

Xrayser

Xrayser CD

Workers disunited

Pay and working conditions must be the main concerns of any employee-dominated group of workers, so it's no surprise that these are the main issues on pharmacists' minds (C+D, September 2, p4).

Employees normally vote with their feet, but pharmacists' choice is limited as a few large multiples increasingly dominate the market. The disaffected band together and take industrial action – again not really an option for pharmacists. Pharmacy's unique form of protest at employees' lot is to become a locum.

The fact that locums represent over a third of the community pharmacy workforce is a sad reflection of the true level of dissatisfaction with employers. There are few benefits to becoming a locum, other than avoiding the overbearing duties of administration, excessive hours and company politics that accompany employee status. There are no career prospects, reduced job satisfaction, and no holiday or sick pay, pension rights or bonus schemes.

Many locums say the freedom to choose their working hours is an important advantage, but outside pharmacy most employers have found an effective way to keep their staff happy. It's called flexitime or jobshare, or even part-time, and enables them to retain good staff who repay them with loyalty and hard work. And surely the limited tax benefits of self-employed status don't make up for the complete absence of any job perks.

Employers' lack of effort at retaining staff could reflect the fact that all pharmacists do basically the same job for more or less the same money, and could be considered interchangeable. This is surely not the thinking of a progressive company.

With 13 per cent of community pharmacists planning to leave the profession within two years, increasing numbers of new graduates look set only to dilute the pool of talent and experience available to employers. If the multiples continue with their plans to take over the profession they must realise their responsibilities or risk shooting themselves in the foot. A shortage of workers is a downward spiral for the profession.

CD

24 tablets inside

Xrayser CD

Chesty, dry, or just plain placebo?

I already knew that there was little or no clinical evidence for the effectiveness of OTC cough remedies (C+D, September 2, p24), but can that great medicinal feeling of a spoonful of Benylin or Robitussin really be all in the mind? I suspect it might be, but that doesn't make it worthless. If acute coughs cost the economy £979 million every year, anything that makes people feel better must be worthwhile.

But if all OTC cough medicines are equally ineffective my "chesty or dry?" patter is only useful as a method of eliminating sinister conditions requiring referral. But that role alone is extremely valuable, as I'm sure many serious conditions have been identified and treated as a result of a pharmacy consultation for an apparently innocuous cough. And most people wouldn't consult their pharmacist unless they thought they were going to get some medicine at the end of it, placebo or not.

Cough is a serious problem, significantly impacting on many people's quality of life, and if 25 per cent of chronic coughs cannot be attributed to a specific cause there is clearly more work to be done in this area.

Meanwhile, perhaps I should drop the pretence and, having ruled out any serious conditions, simply ask patients which flavour they prefer.

24 tablets inside

Hospital Report

How clean is your ward?

How many surprises were there for those working in hospitals "When Kim and Aggie went to hospital"? Perhaps a few, but certainly not that many.

Most hospital staff will tell you that cleaning today is insufficient. Few blame the cleaning staff. Across the board, cleaning staff do the best they can with available resources. Those who remember 15 to 20 years ago will tell you that hospitals used to be much cleaner and there were fewer problems with hospital infections as a result. But then there were twice as many cleaning staff.

The decline began with the introduction of trusts. Many trusts' first action was to privatise their cleaning staff. Many staff committed to the NHS left at that point. Pay and working conditions worsened, money was saved and the accountants were happy. Patients? Superbugs? Obviously they just complicate matters and were not really considered in this.

When cleaning contracts were taken back into NHS ownership, pay and conditions improved, but numbers of staff did not increase significantly as pressure from the accountants was still there.

Those who remember 15 to 20 years ago will tell you that hospitals used to be much cleaner and there were fewer problems with hospital infections as a result

Our pharmacy used to have two cleaners working five hours each every day. Today we have one cleaner for only two to three hours a day. The wards are slightly better off, but not much. It therefore came as no surprise that the new, PFI-built, Edinburgh Royal Infirmary was the dirtiest major hospital in Scotland. The effect of PFI on staffing levels is now being questioned. Is it not obvious? Surely hygiene must take precedence over accountants? If the accountants were hospitalised I'm sure they would agree.

Written by a senior hospital pharmacist

Chemist+Druggist

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gal stimulants, pregnancy tests,
diction counselling and hangover
medies. We don't have a
oblem with talking about such
rsonal issues; we like doing it.
We also hand out bookmarks to
udents with their prescription
edicines, which are printed with
eful local phone numbers such as
practices, A&E and libraries.
We're very pro students – they
ing in 50 per cent of my business –
ey're high spenders and our
rnover has leapt since we decided
target them.

ere there difficulties?
e main problem with chlamydia
sts is the paperwork. The form
oks awkward and it's quite tricky to
mplete. I help patients to fill it in.
e test results are usually relayed to the patient by mobile phone as a text message. They would have to go to a sexual health clinic if they needed antibiotics, but I am working on a PGD to enable me to prescribe them.

How have the locals reacted?
I'm part of the local community just like a local clergyman used to be or a schoolteacher. I have my own clientele and I provide them with the best service that I can – the shop is clean and bright and the staff wear uniforms. Customers vote with their feet, so I do what I can to keep them coming to me. You can't do anything other than your best. I also know all the GPs, they come into the shop at weekends and we talk.

Any advice for others?
These days you have to sell the services you offer that bit harder. You've always got to keep moving forward and looking for new ideas. I love what I do, I think I'm the luckiest person alive.

Name
Raymond Hall

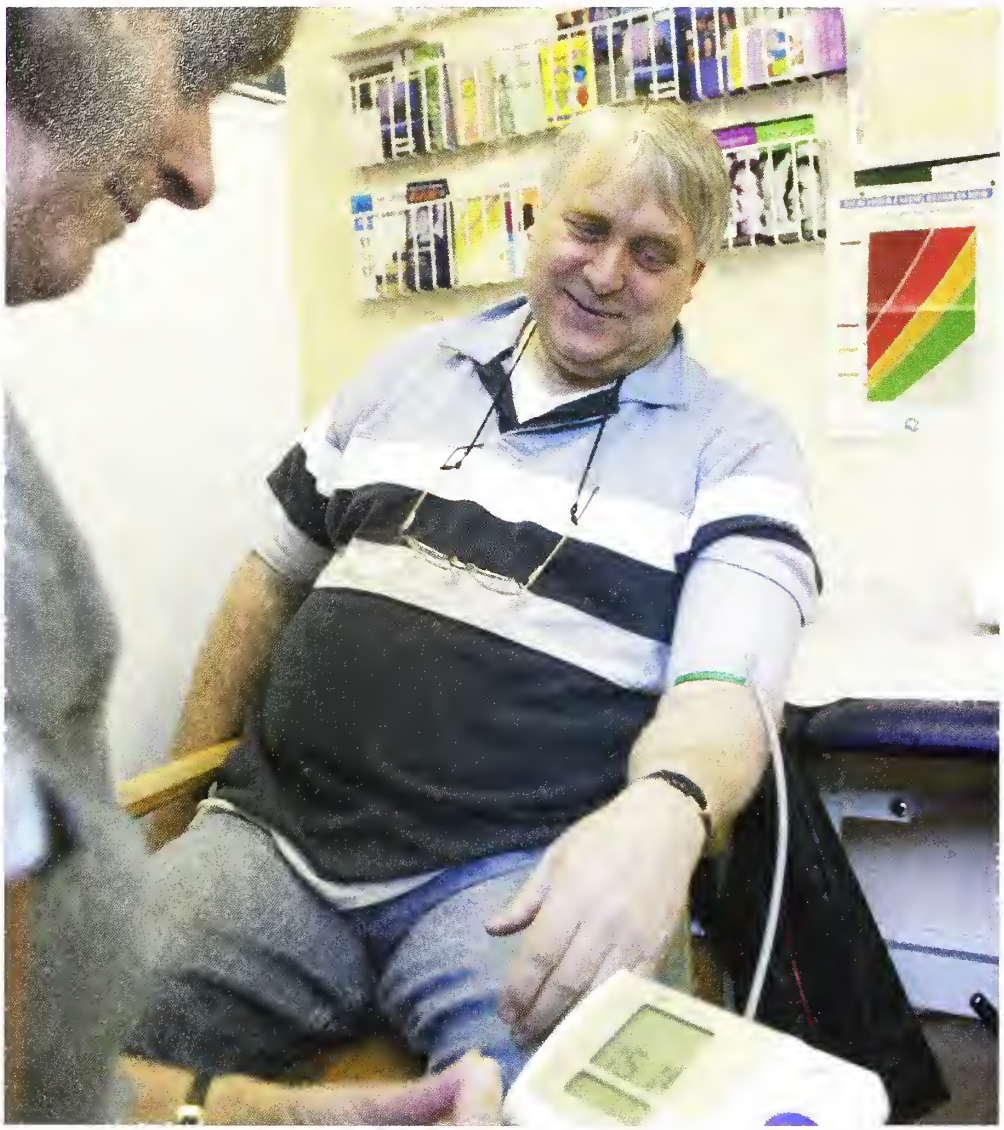
Pharmacy
Raymond C Hall, Hull

What has he done?
Offers a chlamydia screening and EHC service

Nominate your Pharmacy Champion: 01732 377688 or chemdrug@cmpmedica.com

Long-term benefits

The British Pharmaceutical conference this week highlighted the increasing potential for pharmacists to be more actively involved in supporting people with long-term conditions



Every healthcare system.... is faced with a big rise in people with long-term health conditions

David Colin-Thomé

Sarah Thackray

Long-term conditions are *the* health issue for the 21st century. That's the view of Dr David Colin-Thomé, national clinical director for primary care. "Every healthcare system, including those in the developing world, is faced with a big rise in people with long-term health conditions. This is particularly marked in Western Europe because of the fact that people are living to quite advanced years," he says.

In the UK, over 15 million people are living with a long-term condition such as diabetes, asthma or arthritis. The majority of them are leading full and active lives with only occasional contact with health professionals and provide much of their care themselves, adapting their lifestyles in response to changes in symptoms. However, up to a quarter of those affected have more severe symptoms and a higher risk of hospital admission.

Long-term conditions account for eight out of the top 11 causes of hospital admissions. The services are there to help patients when their condition reaches crisis point but often fail to provide the ongoing, co-ordinated support needed to prevent such crises from happening in the first place.

Better care and improved lives

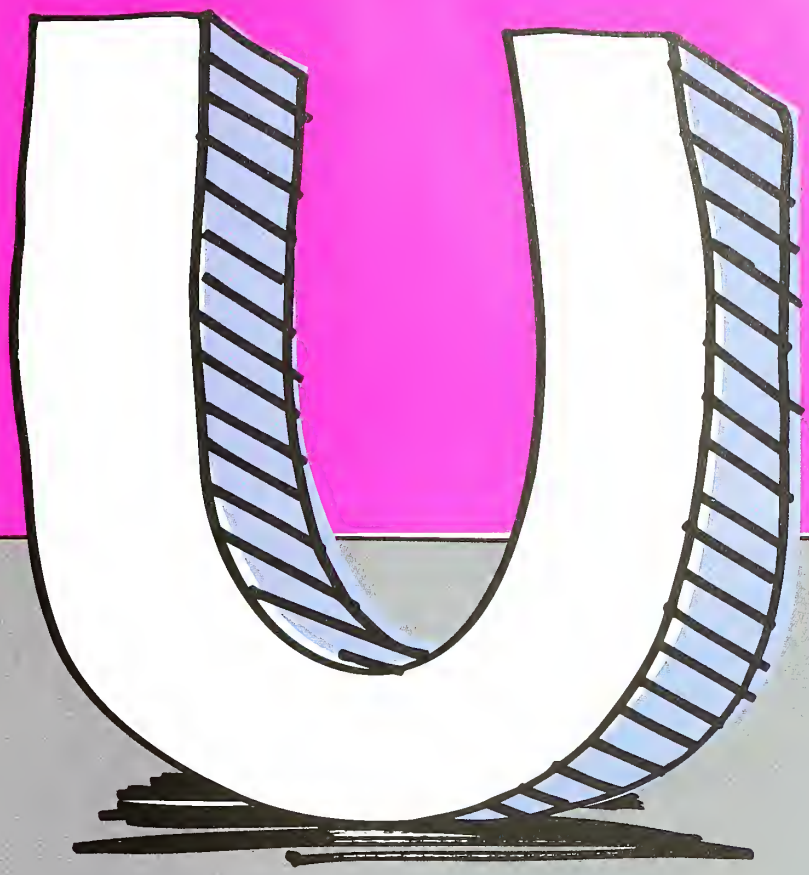
The NHS is trying to pave the way towards better care and improved lives for patients with long-term conditions. The aim is to prevent unnecessary hospital admissions due to these conditions not being managed properly and to treat patients sooner, nearer to home and earlier in the course of disease. This involves earlier detection, good control to minimise the effects of the disease and more effective medicines management.

For this to be carried out, the NHS is having to learn to work in new ways and is developing co-operative plans for patient care that involve primary and secondary care, GPs, consultants, social services, nurses and community pharmacists.

A combination of expertise in medicines management and widespread accessibility makes community pharmacists ideally placed to provide support for people with long-term conditions and help limit inappropriate hospital admissions. Additional services can usually be provided cost-effectively as most of the costs of the community pharmacy network are already met via the NHS contractual framework.

The new community pharmacy contract now supports pharmacists to focus on patients with long-term conditions through providing a medicines use review (MUR) service and via pharmacy enhanced services to support PCTs with their local healthcare objectives. Community pharmacies can be key players in testing and diagnosing, reviewing and educating patients about their conditions and how to manage them, medicines management, care co-ordination and early recognition of deterioration in patients.

Giving patients advice and support about their medicines is an important element of self-management of long-term conditions. Research shows that around half of the patients with a long-term condition do not take their medicines as prescribed. These patients need fast and convenient access to medicines, involvement in decisions about those medicines, advice about how to take them and information on ▶



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any side effects which they may suffer.

"With this group of patients we often see lots of wastage as medicines go unused, people's health deteriorates and quality of life can be compromised," says Mimi Lau, director of professional services at Numark.

She stresses the value of empowering these patients to take greater control of their conditions and thereby live independently and have a fulfilling life. "We need to encourage these patients to become 'expert patients' – having a clear understanding of their condition, how they can help themselves and therefore becoming more likely to take control," she says.

Key role for pharmacists

The government has divided the support of long-term conditions into four areas, all of which have an important role for the pharmacist:

• **Healthcare promotion and advice**
Community pharmacists are particularly accessible to the public for this role.

• **Supporting people who are fairly stable**
These people need support to be more confident in caring for themselves and require occasional reviews by clinicians. Pharmacists play a key role as they are used to talking to the public and giving advice about how to look after themselves.

• **Supporting people who have specific diseases that are much more difficult to control**
Pharmacists need to work closely with other medical professionals.

• **Supporting people who have multiple problems**
These people are often elderly and can spend a disproportionate amount of time in hospital which may not be necessary with more proactive care in the community setting. Many of these people are on a complex medication review and need to be given a great deal of support and the confidence to help themselves. Again, pharmacists need to work closely with other medical professionals.

Advances in point-of-care testing technology mean that pharmacists can now provide accurate results for tests such as glucose, cholesterol and anti-coagulant status with relatively simple to use equipment. Further advances will allow more tests to be offered in the future.

Carrying out monitoring tests on site at the pharmacy is quicker for patients and also creates a better link between medication and its effect, enabling the pharmacist to modify a dosage there and then or advise on other lifestyle changes to help people better control their condition.

"Pharmacists are ideally placed to facilitate early diagnosis of long-term conditions such as diabetes, steering patients towards the appropriate healthcare professionals and treatment," says Meera Sharma, UniChem's professional services manager.

"By catching the early signs, the patient's quality of life can be drastically improved by reducing the onset of complications related to long-term conditions. Many of these conditions require continual monitoring to facilitate easy detection of any related complications and, again, the pharmacist is ideally placed to provide this."

Ms Sharma is convinced that pharmacists will greatly enhance their professional image by extending their services for people with long-term conditions. "It will also increase patient loyalty to the community pharmacy," she says.

Impact of pharmacy care

New report highlights role of community pharmacy

The Royal Pharmaceutical Society of Great Britain has been working with the Department of Health (England) to identify how pharmacists can contribute to the care of people with long-term medical conditions. The RPSGB has produced a new report this week showing evidence of the impact that community pharmacy can have in the care of people with asthma, diabetes and coronary heart disease. Designed for commissioners, community pharmacists and providers of services, Long-term Conditions: Integrating Community Pharmacy is available from www.rpsgb.org

The report identifies seven key criteria for a good pharmacist-supported service for people with long-term conditions:

• The pharmacist assesses the patient's readiness to change and adjusts the start date for the intervention where necessary.

• The pharmacist provides education on the disease, helps identify key issues (eg triggers in asthma) and works with the patient to develop an action plan for self-management.

• The patient participates in all decisions (eg where the pharmacist intends to make a recommendation about a change in treatment).

• Therapy is monitored by the patient together with the pharmacist.

• The pharmacist takes responsibility for outcomes and promotes evidence-based care. Outcomes are measured across a range of indicators (patient acceptability, hospital admissions etc).

• The pharmacist-patient interaction is based on appointment and occurs in ▶

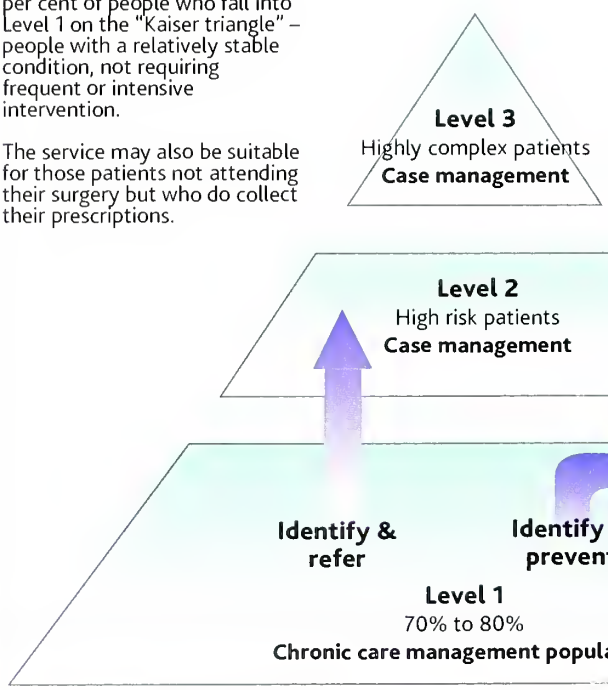
Therapy is monitored by the patient together with the pharmacist

Darren Eccles from Focus Pharmacy in Oldham is one of the first pharmacists to take part in the Greater Manchester Pharmacy Project

Who is this service for?

Predominantly for the 70 to 80 per cent of people who fall into Level 1 on the "Kaiser triangle" – people with a relatively stable condition, not requiring frequent or intensive intervention.

The service may also be suitable for those patients not attending their surgery but who do collect their prescriptions.



Who is it not for?

Patients who fall into Levels 2 and 3 whose care should be maintained by the practice or secondary care clinic. Inclusion and exclusion criteria have been identified for local agreement. At the same time a 'traffic light' system will operate from the computer system to allow pharmacists to identify and refer/prevent patients from moving into these levels.

Manchester pharmacies provide patient choice

In a DH sponsored pilot across Greater Manchester, up to 6,000 people with diabetes and/or cardiovascular disease will soon be offered the choice of having their next consultation carried out in an approved pharmacy. The choice is being offered as part of GP-delegated care and the visit to the pharmacy to collect medicines includes point of care blood tests for HbA1C, cholesterol, HDL-cholesterol, triglycerides and INR (for anticoagulant management).

The pilot supports the integration of pharmacy into healthcare delivery under the new pharmacy contract and enhances patient choice, convenience and access to healthcare outside hospitals. The service was launched in two pharmacies in August and will be offered in 21 pharmacies by November.

Clinical consultations include lifestyle discussion, diet, exercise regimens, medicines compliance/concordance, height, weight, blood pressure measurements and calculation of BMI.

Data gathered in the consultation is entered into an online IT system that inserts the information into the patient record and the GP's quality and outcome framework record. A paper report is printed for the patient and a recall system is used to arrange follow-up visits.

This service is predominantly for the 70 to 80 per cent of people who fall into Level 1 on the 'Kaiser triangle' (see opposite) – people with a relatively stable condition, not requiring frequent or intensive intervention.

The care of patients who fall into Levels 2 and 3 is maintained by GP practices or secondary care clinics. A 'traffic light' system operates from the computer system to allow pharmacists to identify and refer/prevent patients from moving into these levels.

Pharmacists will be paid an annual patient management fee similar to that provided for other pharmacy services such as smoking cessation. Episodes of care are designed to last about 25 minutes. Where the 'traffic light' system indicates more intensive management is required, additional episodes will need to be scheduled (albeit within the same management fee).

Each pharmacy also receives a grant to update their patient consultation facilities to standards beyond those required by the new pharmacy contract. These include a private/enclosed room with space for diagnostic testing equipment and computer/broadband connection.

Pharmacists attend a two-day training course, which includes consultation skills and point of care testing. Pharmacy staff also take part in a one-day programme covering point of care testing.

"Pharmacists have been very keen to get involved with this project and see it as an opportunity under the new pharmacy contract," says Gilbert Wieringa, project director, diagnostics, Greater Manchester Strategic Health Authority.

He adds: "The benefit to patients is easy access and being able to attend the pharmacy at a convenient time rather than having to make an appointment with a GP. It also encourages greater ownership of results as people get them immediately instead of making two or three journeys."

The pilot will run until the end of 2007.

Scale of pharmacy opportunity

The average community pharmacy can expect to serve the following numbers of patients with long-term conditions:

Condition	No of patients
Asthma	452
Diabetes	156
Angina	122
Heart attack (annual)	24
Hypertension	1390
Heart failure	78
COPD	78
Epilepsy	40
Rheumatoid arthritis	35
Parkinson's disease	10

...cash-releasing savings from disinvestments elsewhere cannot always be relied upon...

a private consultation area.

- The patient's GP is informed or consulted about all test results and interventions.

The report points out that these criteria will be useful for pharmacists in self-assessing their competence and as a basis for CPD. It also highlights five measures which will help enable the pharmacist to provide such a service:

- Multidisciplinary involvement.
- Externally recognised certification of programme.
- Acceptance by referring doctors who require credibility of both pharmacist and service processes, leading to development of trust, with successful patient outcomes.
- Effective marketing to doctors and patients.
- Reimbursement for the pharmacist.

Pharmacy opportunity

Research shows that community pharmacists are keen to specialise in this area, recognising it as a core element of the service they provide. In a recent survey, 65 per cent of pharmacists expressed an interest in specialising in the management of long-term conditions.

Ajit Malhi, professional services manager at AAH Pharmaceuticals, believes this is an ideal time for pharmacists to extend their support for people suffering from long-term conditions. "With the onset of practice based commissioning, pharmacy has the opportunity to support medical practices in ensuring that local healthcare needs are met and that patients with long-term conditions are supported in managing their condition. This will free up resources within the practice to focus on patients with more immediate issues and also support the NHS objective of reducing referrals into secondary care that can be avoided," he says.

"Pharmacy benefits from this new approach as it can truly exploit its skills to benefit patients and contribute positively to improving the health of the nation through a collaborative approach with GPs and other allied healthcare professionals such as nurses. At last pharmacy can work as part of the wider NHS team."

What about funding?

The RPSGB report says that community pharmacy can be a highly cost-effective part of the integrated package of care for people with long-term conditions. However, it also points out that funding is required to meet additional costs and experience shows that cash-releasing savings from disinvestments elsewhere cannot always be relied upon to fund new services.

The new community pharmacy contractual framework offers opportunities for funding new provision. However, only 1 per cent of community pharmacists in England are currently commissioned

Pharmacist Akshay Patel advises asthma patient Liz Roe at Wells Green Lloydspharmacy in Coventry

Pharmacy role in asthma control

Following the success of an asthma MUR pilot project in 200 Lloydspharmacy stores, an asthma support service has now been introduced in 1,350 of the group's pharmacies throughout England and Wales.

Developed in partnership with Asthma UK, the scheme identifies people who are experiencing difficulties controlling their asthma symptoms by asking them to complete a simple questionnaire on asthma control.

Those whose asthma symptoms are shown not to be under control are invited to attend an MUR with a pharmacist who advises on inhaler technique and refers the individual to their GP for an asthma review if necessary.

Nick Mortimer, superintendent pharmacist at Lloydspharmacy, comments: "Our asthma MUR pilot clearly showed that community pharmacy has an important role in long-term management of chronic conditions such as asthma. Research conducted during the initial trial showed that 27 per cent of the patients had not had a review with their GP or asthma nurse in the previous 12 months."

The pilot also showed that 74 per cent of asthma patients were experiencing daytime symptoms, over a third of all patients were using their inhalers incorrectly and around 50 per cent of patients needed further education.

"These statistics highlight the important part pharmacists can play in assessing asthma control and making a positive impact on the lives of people with asthma," says Simon Selo, Asthma UK's assistant director for service development.

The government's objective is for people with complex problems to have a community matron

by PCTs to provide disease-specific medicines management services (Health and Social Care Information Centre 2006).

According to Dr Colin-Thomé, national clinical director for primary care, health commissioners in other countries are funding disease-specific community pharmacy services, particularly in asthma and diabetes. "Community pharmacists in other countries are also funded to carry out clinical medication reviews for housebound patients and those in care homes."

He believes the combination of the implementation of the new pharmacy contract and the government's policy on long-term conditions have resulted in far more focus on the important role of pharmacists in this country. "For the first time, community pharmacists are being seen as key front line clinical staff and I don't think that was recognised in the past."

Dr Colin-Thomé acknowledges that there has always been the potential for community pharmacists to be more actively involved in the actual assessing of patients rather than solely in the medication review. While recognising that some community pharmacists have been working as locally accredited services in the past, he says "the pharmacy contract will make this service more general rather than just having a few innovators scattered around the country."

How common is chronic disease?

- Arthritis affects around nine million people in the UK – one in five of the adult population and 12,000 children.
- There is a person with asthma in one in five households in the UK. 5.2 million people in the UK are currently receiving treatment for asthma including 1.1 million children. Seven out of 10 people with asthma do not have the disease under control.
- More than two million people in the UK have diabetes and it is estimated that a further one million have diabetes but don't know it. Over three quarters of people with diabetes have type 2 diabetes.
- Around 450,000 people in the UK have epilepsy and one person in 20 will have an epileptic seizure at some time in their life.
- Multiple sclerosis (MS) is the most common disabling neurological condition affecting young adults. Around 85,000 people in the UK have MS and it is more common in women than in men – the ratio is 3:2.
- Around 120,000 people in the UK have Parkinson's – that's one in 500 of the population. Men are slightly more likely to develop Parkinson's than women.

Helping patients become experts

Doctors undertaking follow-up and care of patients with long-term medical conditions like diabetes mellitus, arthritis and epilepsy have acknowledged that "my patient understands his/her disease better than I do". People living with long-term conditions become 'experts' in their own right because they have acquired the life skills to cope with a chronic condition and have the potential to be confident partners with professionals in their care.

Self-management initiatives such as the Expert Patient Programme (EPP) are already leading to better health for patients, improved medicine taking, fewer complications and a greater sense of control in coping with day-to-day illness. The EPP is an NHS-based training programme that provides opportunities for people who live with long-term chronic conditions to develop new skills to manage their conditions better.

The programme recognises that people with all kinds of long-term conditions are dealing with similar issues on a daily basis. These include pain management, stress, low self-image and the development of coping skills. The course is run over six consecutive weekly sessions where two volunteer tutors cover topics such as relationships, diet, exercise, fatigue, breaking the symptom cycle, managing pain and medication and communication with healthcare professionals.

Maggie, who has arthritis and osteoporosis, is typical of those with long-term conditions who have benefited from an EPP programme. She says: "The course helped me in many ways. Most of all, it gave me back my confidence and independence. I now do much more for myself. I use the buses again like I used to without having to ask my husband to take me everywhere. My GP has noticed an improvement in me."

The government aims to increase EPP capacity from the current 12,000 course places a year to more than 100,000 by 2012.

Course details: www.expertpatients.nhs.uk

The government's objective is for people with complex problems to have a community matron who will link with other key medical professionals. It is working towards a target of having 3,000 community matrons in place by 2007 alongside other case managers to tackle the most complex multiple problems; specifically community matrons will be nurses.

"Our view is that all people with complex problems, whether single or multiple, need a care plan worked out between the patient/carer and their main clinician and that will include co-ordinating care," says Dr Colin-Thomé. "The case manager could be the community pharmacist, the doctor or anybody that seems the most appropriate. What we want to get away from is the idea that only one single professional can do it. This would be a new role for the community pharmacist but there is nothing to stop any professional, if they have got the knowledge and skills, doing that job."

The way forward

Dr Colin-Thomé advises pharmacists to speak to practice based commissioners who have the budgets for the care of their patients. "Once GPs realise how much better they can redesign care for their patients, especially those with long-term conditions, they will recognise the key role of the pharmacist. GPs already recognise the worth of community pharmacists but they probably haven't appreciated their value in the clinical review of patients."

"At the moment many people with long-term conditions are not effectively treated which means that we need to be prescribing more drugs for many of them. This is especially true in socially deprived areas," says Dr Colin-Thomé. "If pharmacists can provide this clinical role, either the PCT or the practice based commissioner may well give them a contract or, in some cases, they may want to be part of the practice based commissioning forum and share in the benefits that they might get in terms or resources. GPs can put money into enhancing services they provide and that could help to subsidise and enhance pharmacy services, which in itself could attract more customers.

"As we begin to reshape care and fewer patients need to be sent to hospital, those resources can be put into developing primary care based services which the pharmacist would be a key part of – either through a contract or by being part of the group that can use the money to expand services," he says. "Pharmacists have to demonstrate their effectiveness and push themselves with groups that they haven't traditionally worked closely with. Go out and create a space for yourselves!"

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- Hedrin is still the only licensed pharmacy medicine which does not contain pesticides
- Back on national TV in August and September with further support in the national press and women's magazines throughout the back-to-school period.

[1] IRI 4 w/e 17th June 2006 £ sales
[2] D R Thomas et al, Arch Dis Child 2006;000:1-3

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Product Information Hedrin 4% Lotion. Presentation: cutaneous solution containing 4% dimeticone w/w. **Indications:** for the eradication of head lice infestations **Dosage and administration:** Adults and children over 6 months: Apply sufficient lotion to cover dry hair from the base to the tip to ensure that no part of the scalp is left uncovered. Work into the hair spreading the liquid evenly from roots to tips. Allow hair to dry naturally. Hedrin should be left on hair for a minimum of 8 hours or overnight. Wash out with normal shampoo, rinsing thoroughly with water. Repeat the treatment after seven days. **Contraindications:** Hypersensitivity to any of the ingredients. **Precautions and Warnings:** Discontinue at the first appearance of a skin rash or any other signs of local or general hypersensitivity. For external use only. If accidentally introduced into the eyes, flush with water. **Side Effects:** Minor adverse events include an itchy or flaky scalp and dripping/irritation around the eyes. **Product License Holder:** Thornton & Ross Ltd, HD7 5QH **Legal Category:** P **Price:** MRRP ex VAT: 50ml £4.25, 150ml £9.78 Product License No: PL00240/0137 **Date of preparation:** December 2005.

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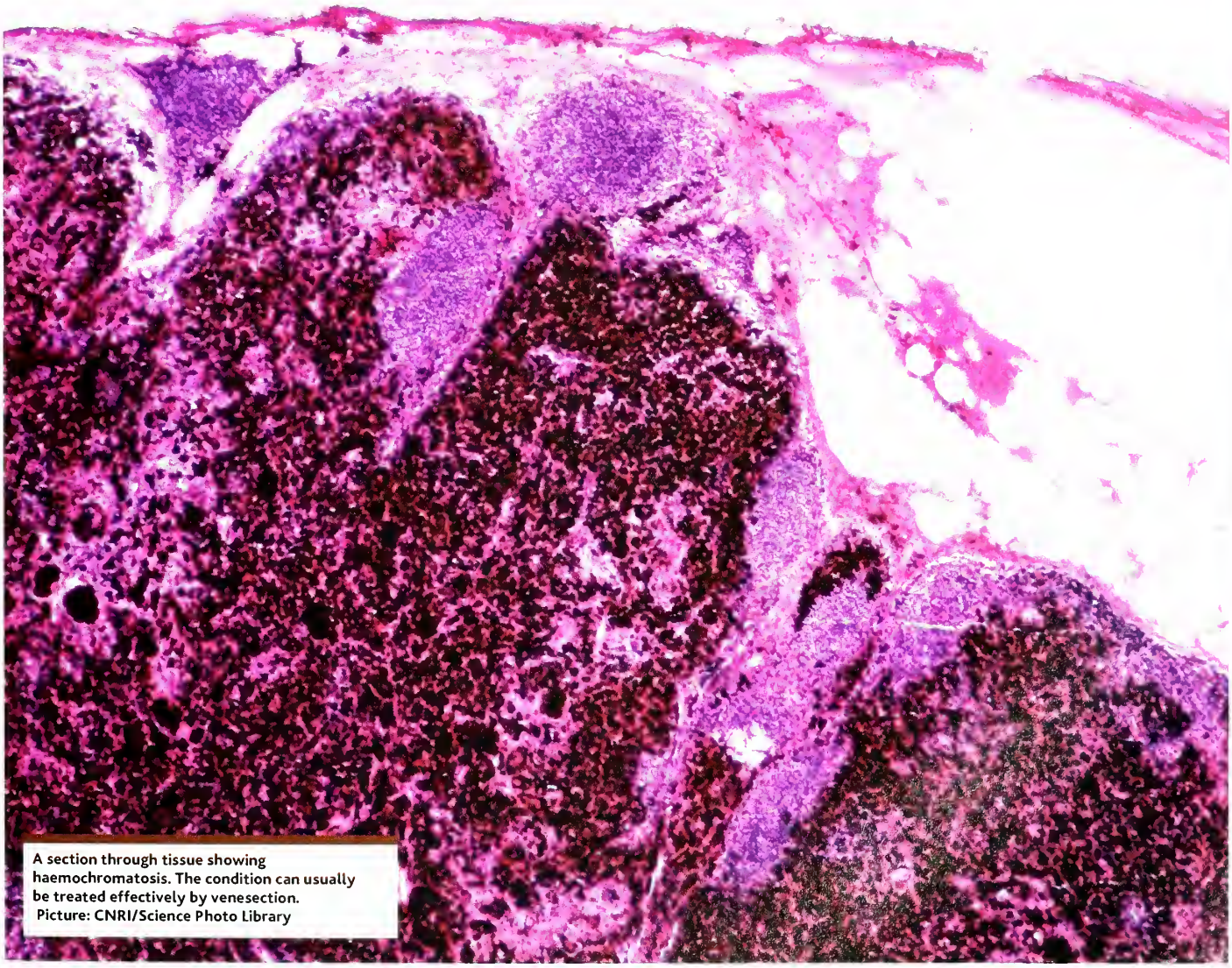
Metal fatigue

C+D looks at the causes of iron overload and its management with chelation therapy, for which a new drug looks soon to launch



A section through tissue showing haemochromatosis. The condition can usually be treated effectively by venesection. Picture: CNRI/Science Photo Library

Simon Cheesman

Iron is an essential element for a range of metabolic processes, forming a key component of many different enzymes as well as the oxygen-binding molecules haemoglobin and myoglobin.

The physiological versatility of iron stems from its readiness to donate or accept electrons, converting between the ferric (Fe^{3+}) and ferrous (Fe^{2+}) forms in the process.

The capacity to act as an electron donor also gives iron the potential to damage body tissues; the ferrous form reacting with hydrogen peroxide to generate free radicals.

Iron in the body is usually found bound to protein carriers, thereby reducing this potential for tissue damage.

Absorption, distribution and control of body iron

The average Western diet provides about 15mg of iron each day but the body takes up only a small percentage – an average of 1 to 2mg per day. The amount absorbed, mostly in the duodenum, depends largely on three things: recent iron uptake, total body iron stores and the bioavailability of the dietary iron. Before it can be absorbed, iron must be reduced to the ferrous form by the action of ferric reductase

CPD This article can help you with the following CPD competencies: G1c, G1c, G1f, G8a, C1c www.tinyurl.com/19

Table 1: Conditions commonly necessitating regular blood transfusions

Thalassaemia (major or intermedia)
Myelodysplastic syndromes
Sickle cell anaemia
Myelofibrosis
Osteopetrosis
Aplastic anaemia
Diamond-Blackfan anaemia
Fanconi's anaemia
Congenital dyserythropoiesis

enzymes situated on the apical surface of duodenal epithelial cells.

Uptake of iron is balanced by loss due to desquamation of skin or mucosal cells and by blood loss. In this way, the total body iron content of a healthy individual remains stable, usually at around 50mg/kg in an adult male and 40mg/kg for a female. Pre-menopausal women have lower body iron stores because of repeated menstrual blood loss.

The largest proportion of iron exists as haemoglobin in circulating erythrocytes and in erythroid precursor cells. Most of the remainder is stored in the reticuloendothelial cells of the liver, spleen and bone marrow, where it is bound to the proteins ferritin and, to a lesser extent, haemosiderin. Iron in the circulation is bound to transferrin and transferred to sites of storage or utilisation.

Another major site of iron storage is the parenchymal cells of the liver. These cells take up first-pass iron released from dietary nutrients together with any circulating iron exceeding the binding capacity of transferrin. Under normal physiological conditions only a trace amount of iron exists in an unbound state.

The control of total body iron content occurs at the absorption stage, as there is no physiological mechanism for excess iron excretion. This is important when considering the causes and treatment of iron overload.

Causes and consequences of iron overload

The three main causes of severe iron overload are excessive iron intake, inappropriately increased absorption of iron and repeated blood transfusions.

Excessive iron intake may result from overzealous parenteral therapy or dietary overload. The latter occurs most frequently in Sub-Saharan Africa due to excessive consumption of an iron-rich beer coupled with a genetic susceptibility to increased absorption, so-called 'Bantu siderosis'.

Inappropriately increased absorption occurs in patients with hereditary haemochromatosis or disorders characterised by ineffective erythropoiesis, such as beta-thalassaemia intermedia or sideroblastic anaemia, where excessive absorption occurs despite an inappropriately large total body iron store.

Haemochromatosis is an autosomal recessive disorder. The gene causing the disorder, HFE, was discovered in 1996. Since then, mutations in other genes involved in iron metabolism have been found to cause similar problems of iron overload. Patients with haemochromatosis absorb two to three times more iron from their diet than a normal person, with the excess being deposited in the parenchymal cells of the liver, heart, pancreas, parathyroid and pituitary glands. Venesection (cutting a vein to remove blood) is usually an effective treatment, as erythrocyte regeneration in the patient's bone marrow uses the excess iron.

The inappropriate deposition of iron may cause tissue damage and eventually organ failure and is one of the commonest consequences of the third major cause of iron overload – repeated blood transfusions. One unit of donor blood contains about 200mg of iron and overload may occur quickly with repeated transfusions. To reduce or prevent the potentially fatal cardiac and hepatic complications, therapy with iron-chelating drugs is indicated at an early stage in those patients who require lifelong blood transfusions (Table 1).

Iron-chelation therapy

The aim of iron-chelation therapy is the continuous removal of a sufficient quantity of iron to prevent damage to the liver, endocrine organs and, most crucially, the heart. The decision to start therapy may depend on reaching a certain number of blood transfusions (10 to 20) or when serum ferritin becomes elevated above a certain level (1,000 micrograms per litre).

As only a tiny proportion of iron in the body is free and available for binding at any one time, chelation therapy needs to be given continuously. There are currently two licensed iron chelating drugs available in the UK, with a third expected to be launched this month.

Desferrioxamine mesilate

Desferrioxamine was introduced in the 1960s and is the UK's most commonly prescribed iron chelator. Derived from the bacterium *Streptomyces pilosus*, it is a hexadentate molecule, meaning that at normal physiological pH one molecule of the drug binds to one iron atom (iron has six co-ordination sites that require binding). This results in the formation of a relatively stable complex (ferrioxamine), which is readily soluble in water and excreted via the kidneys (giving the urine an orange colour) and bile.

Unfortunately, because of low oral bioavailability, desferrioxamine must be given parenterally. Also, because of the drug's short half-life and the small amount of iron available for binding at any one time, it is most effective when given as prolonged infusions. This combination of factors means major compliance problems for patients, who are likely to be attached to an infusion pump for a large part of the day, several days each week. This is important, as compliance with treatment is a crucial determinant of survival. For example, one study showed that 95 per cent of patients who received more than 250 infusions of subcutaneous desferrioxamine each year were alive at age 30, compared with 12 per cent of those who did not meet this target.[1]

The dose of desferrioxamine is 30 to 50mg per kg given as a subcutaneous infusion over eight to 12 hours on five to seven days of the week. Doses in this range are usually sufficient to maintain an acceptable body iron content. Higher doses or intravenous administration may occasionally be required for patients who are already iron overloaded or in whom cardiac toxicity has developed.

Supplementation with ascorbic acid 100 to 200mg given on the same day as each infusion increases the availability of ferrous iron for chelation and increases its urinary excretion. However, impaired cardiac function has occurred in severely iron-overloaded patients receiving higher doses of ascorbic acid, so supplementation should be initiated only by a hospital specialist, usually at least a month after starting the infusion regimen. Patients can either be taught to reconstitute and administer the infusions themselves or have them reconstituted by a hospital pharmacy sterile production unit and delivered. This latter arrangement is expensive but may substantially improve compliance and PCTs can usually be persuaded to bear the cost of home delivery.

Restricting the drug concentration to less than 10 per cent, varying the site of administration or adding hydrocortisone to the infusion solution can all help to reduce local irritation, the main side effect of infused desferrioxamine. Superficial siting of the injection needle can also contribute to irritation. Retinal damage (particularly in people with diabetes), high frequency hearing loss and infection with Yersinia are other relatively common side effects.

Treatment efficacy is monitored by serum ferritin levels and by assessing hepatic and

Key points

- Repeated blood transfusions lead to the accumulation and deposition of iron in the body.
- Deposited iron may cause tissue damage and organ failure, particularly the heart, liver and endocrine glands.
- Iron chelation therapy with desferrioxamine has long been the standard treatment for iron overload, reducing cardiac complications and improving survival.
- Treatment compliance is often sub-optimal as desferrioxamine must be given by prolonged continuous subcutaneous infusions, on several days each week.
- Deferasirox is a new iron chelating drug that is orally bioavailable and well tolerated, which may improve treatment compliance.

cardiac iron content. As ferritin levels fall, the dose of desferrioxamine may be decreased. Hepatic iron content can be measured by liver biopsy or non-invasively using magnetic biosusceptiometry. Biopsy of the myocardium is an invasive technique and less useful because of the uneven distribution of cardiac iron. Measurement of left ventricular ejection fraction and the detection of arrhythmias using electrocardiograms are both useful assessments of cardiac function. More recently an MRI-based technique has been used to estimate the heart's iron content.

Deferiprone

Deferiprone is an orally bioavailable bidentate iron chelator, three molecules of drug being required to bind one iron atom. The resulting complex is less stable than that formed by desferrioxamine and iron.

Deferiprone is licensed for the treatment of iron overload in thalassaemic patients who cannot tolerate desferrioxamine and the usual dose is 25mg/kg (rounded to the nearest 250mg) three times each day. Response varies between patients, probably related to the speed at which the drug is inactivated by glucuronidation.

The increased ability of deferiprone to cross cell membranes (it is a small, lipophilic molecule) may account for its seemingly improved ability to mobilise cardiac iron when compared with desferrioxamine, although this cardioprotective effect has not been confirmed in long term prospective studies.

Agranulocytosis is the most serious adverse effect of deferiprone, occurring in about 1 per cent of patients. Less severe neutropenia may occur in a further 3 to 4 per cent of those treated. Regular monitoring of the patient's full blood count is indicated and treatment should be halted if the neutrophil count starts to fall. Reintroduction of deferiprone should occur only under close monitoring.

Other side effects include painful swelling of the knees or other joints, abnormal liver function tests, nausea and zinc deficiency. The drug is teratogenic in animals and is contraindicated in pregnancy or those trying to conceive.

Combination treatment with desferrioxamine and deferiprone has been used in an attempt to exploit a potential 'shuttle' effect. This concept involves deferiprone entering cells, chelating iron and returning to the circulation where the iron is then transferred to desferrioxamine and excreted. Compliance advantages could be expected by reducing the number of days each week that a desferrioxamine infusion is required. Combination treatment warrants further investigation.

Deferasirox

Deferasirox is an oral iron chelator that is expected soon to be licensed for treating chronic iron overload due to blood transfusions in patients aged two years and over. It is tridentate (two drug molecules binding to one iron atom) and predominantly increases the excretion of iron via the faecal route.

The recommended starting dose is 20mg per kg daily (range 10 to 30mg/kg), rounded to the nearest tablet size (125mg, 250mg and 500mg). The dose should be tailored to the patient's response, monitored by serum ferritin levels. The tablets should be completely dispersed in water, or orange or apple juice. After taking the dose, any residue in the glass should be resuspended in a small volume of fluid and swallowed. The dose should preferably be taken at the same time each day, on an empty stomach, at least 30 minutes before food. Aluminium-containing antacids should be avoided at the same time.

Deferasirox has been well tolerated in clinical trials comparing it with infusional desferrioxamine. The main problematic side effects were gastrointestinal upset, including abdominal pain and diarrhoea, headache and skin rashes.

The availability of a well tolerated, orally bioavailable iron chelator holds much promise for improving treatment compliance and clinical outcomes in transfusion-dependent patients.

Reference:
1. Gabutti, V, Piga, A. Results of long-term chelation therapy. Acta Haematologica (1996) 95, 26-36.

Simon Cheesman, MRPharmS, DipClinPharm, is lead pharmacist for haematology at University College Hospital London NHS Foundation Trust.

Continuing professional development

Reflect

Until now, patients with iron overload were treated by infusion so you might never have been involved with their medication. But this could change with the introduction of an oral chelating agent in the coming week. How much do you know about the causes of iron overload and the use of chelating agents?

Plan

This article will tell you more about how the body controls iron absorption and what factors put patients at risk of iron overload. You will learn about existing treatments and their drawbacks, and a new drug you might be asked to dispense.

Act

- Find out more about iron homoeostasis in the body. Draw a diagram showing how iron is bound, in which body cells these compounds exist, how they are transferred and what happens when they are broken down.
- How many of your patients need regular blood transfusions and why? Do you have any patients with haemochromatosis? Make a note of these groups and what chelation therapy they are using. Do they have problems in complying with infusion regimens?
- Would they benefit from oral treatment? If so, what are you going to do about it?
- Are they also taking vitamin C? If so, what doses are being used?

Evaluate

Are you now sufficiently knowledgeable about iron overload to answer questions patients might have about the new treatment? If not, try to find out more.

A Practical Approach...

"Mr Spencer, I've just taken in this private prescription for fentanyl patches, but I don't think we can dispense it," says pre-registration trainee Salma Hussain to pharmacist David Spencer.

"The script looks genuine. I've had prescriptions from this private GP before," says David. "But let's go through it. Does it have all the CD prescription requirements?"

"Yes, except the total quantity in words and figures."

"OK. And what is the quantity and dose?"

"15 x 12mcg/hour patches, one every 72 hours."

"Is it handwritten?"

"No, it's computer generated."

"What sort of form is it on?"

"Just an ordinary private prescription form, but it's got his name, address and qualifications on it, it's signed and it was dated yesterday."

"Is the patient waiting for it?"

"It isn't the patient, he said he was picking it up for a friend. He said he'd be back in an hour."

"Did you ask him for any identification?"

"No, should I have done?"

After a few moments' thought David says: "You're right Salma, we can't dispense this script. But can you tell me exactly why you decided we couldn't."

Questions

1. Why can this prescription not be dispensed?
2. Which points mentioned in the scenario would have rendered the prescription invalid a few months ago but would not now?

CPD This article can help in the following CPD competencies: C6a, G1h, G1m, G1j. See www.tinyurl.com/194zu

Next areas for Nice

The Department of Health has announced that 12 drugs are suitable for fast track consideration by the National Institute for Health and Clinical Excellence. It has also set out a number of public health topics, clinical guideline and technology appraisals it wants Nice to look at for the 12th wave of its new work programme.

The drugs to be assessed under the single technology appraisal (STA) process are:

- Erlotinib (Tarceva) for non-small cell lung cancer.
- Irinotecan (Campto) for adjuvant advanced colorectal cancer (subject to licensing).
- Pemetrexed (Alimta) for non-small cell lung cancer.
- Cetuximab (Erbitux) for locally advanced recurrent metastatic head and neck cancer (subject to licensing).
- Atrasentan (Xinlay) for hormone refractory prostate cancer (subject to licensing).
- Omalizumab (Xolair) for asthma.
- Ximelagatran (Exanta) for atrial fibrillation.
- Lerdelimumab (CAT-152) for glaucoma.
- Carmustine implants (Gliadel Wafers) for glioma (recurrent).
- Nesiritide (Natrecor) for acute heart failure.
- Natalizumab (Tysabri) for multiple sclerosis.
- Infliximab (Remicade) for psoriasis.

Among the public health topics Nice will consider are strategies for reducing harm from smoking with guidance on the prevention of uptake of smoking in children and young people, and management of long-term sickness and incapacity.

Technology appraisal topics include idaraparinux sodium's use in stroke patients with atrial fibrillation and to prevent recurrent venous thromboembolism; verinicline for smoking cessation; alteplase for stroke; drugs for refractory rheumatoid arthritis; psoriatic arthritis treatments; ruboxistaurin for diabetic eye disease; sleep apnoea treatment; and drugs for Crohn's disease.

Vitamin D needed for Asian infants

Primary care trusts should provide funds for vitamin D supplementation of Asian children for at least the first two years of life, says new research.

The authors, who are based at Burnley General Hospital, made the recommendation having verified that vitamin D deficiency is re-emerging in the trust, and particularly among children of Asian origin. They associate the re-emergence of conditions such as rickets in the local population with the ending of vitamin D supplementation by PCTs.

While the patient numbers are small (data from 14 patients identified from the hospital records over 10 years), the authors found that 13 of these were of Asian origin, and that 12 of the cases had occurred in the past five years. When these figures are applied to the wider Burnley population, it represents a vitamin D deficiency of one in 923 children in the general population, but one in 117 children of Asian origin.

"The five-year period during which 86 per cent of our cases presented coincides with the discontinuation of funding for vitamin D supplementation in eligible infants," say the report's authors. They calculate that the cost of primary prevention for the high risk population compares favourably both medically and financially with treatment of established disease.

For more information:
Archives of Disease in Childhood August 2006 online: doi:10.1136/adc.2006.098467

A Practical Approach... last week's answers

1. There is a clinically significant drug interaction. Valproate increases the plasma concentration of lamotrigine, which can lead to increased likelihood of side effects, the main one being a skin rash. The dose prescribed is for lamotrigine monotherapy, and is too high for starting the drug as add-on therapy to valproate – it should initially be 25mg on alternate days.
2. Gillian should be advised about the possibility of a rash and told to report immediately to her GP if one develops. She should also be told to immediately report any signs suggestive of blood disorders, such as sore throat, symptoms of infection such as fever, and bruising. In addition, David should check that Gillian's consultant or GP has told her that adding another anti-epilepsy drug to her therapy increases the risk of teratogenicity if she becomes pregnant.

In brief

Relenza OK for prophylaxis

GlaxoSmithKline has received approval for the use of Relenza (zanamivir) for the prevention of influenza A and B.

Relenza had been licensed for the treatment of patients aged 12 years and above, but its use in prophylaxis and treatment is now approved for adults and children five years or over.

The approval has been given by medicines regulators in 15 European countries including the UK.

GlaxoSmithKline UK Ltd, tel: 020 8990 9000.

Hayfever, eczema may be stabilising

Eczema and hayfever seem to have peaked among the population and may be falling. However, hospital admissions for some systemic allergic diseases have risen sharply, say researchers, which may indicate a change in the aetiology of allergic disease in the UK.

The researchers analysed trends of prevalence, morbidity and mortality for allergic disorders from the 1990s. They found that while allergic rhinitis and eczema in children trebled over the last three decades, the past decade has seen a stabilisation. GP consultation rates rose by 260 per cent for hayfever and 150 per cent for eczema from 1971 to 1991.

But since 1995, hospital admissions for eczema have been stable and admissions for allergic rhinitis have fallen to about 40 per cent of 1990 levels, say the authors.

This contrasts with a 700 per cent increase since 1990 in admission for anaphylaxis, a 400 per cent increase for food allergy, a doubling of admitted urticaria cases and a rise of 40 per cent of angio-oedema cases. Prescriptions for all allergy types has increased since 1991.

"Although changes in treatment and other healthcare factors may have contributed to these trends, there may also be a change in the aetiology of allergic disease in the UK," the researchers from the Division of Community Health Sciences, St George's University of London, conclude.

For more information:
Thora Aug 2006 doi 1136/thx.2004.0388

Flu vaccine strains

Novartis Vaccines has updated its SPC for the Enzira influenza vaccine to reflect the viral strains being used. The split influenza vaccine contains antigens equivalent to: A/New Caledonia/20/99 (H1N1)-like strain (A/New Caledonia/20/99 IVR-116); A/Wisconsin/67/2005 (H3N2)-like strain (A/Hiroshima/52/2005 IVR-142); and B/Malaysia/2506/2004-like strain (B/Malaysia/2506/2004).
Novartis Vaccines, tel: 017276 692255.

Nystan Pessaries

Bristol-Myers Squibb is discontinuing Nystan (nystatin) pessaries in the UK. This is due to commercials reasons, says BMS. Further information is available from the BMS medical information department on 0800 731 1736.

Generic azithromycin

Teva is launching generic azithromycin tablets in 250mg and 500mg strengths. The 250mg is in a pack of four with Pip code 113-1655 and with a retail price of £8.50 (ex VAT), and the 500mg is available in packs of three with a Pip code of 113-1663, and priced £12.76 (ex VAT).
Teva UK Ltd, tel: 0113 238 0099.

Confirming the menopause

The Novogen Menopause Test has been launched to enable women to determine whether they are going through the menopause without seeing a doctor. The test is more than 99 per cent accurate, quick and simple to use, says Novogen. It detects follicle stimulating hormone (FSH) in the urine; consistently elevated levels are indicative of the body's transition to menopause.

According to a survey for the company, 60 per cent of women are likely to use a home test to confirm the menopause. Respondents cited immediacy of results (60 per cent) and peace of mind (62 per cent) as important factors in testing.

A consumer media campaign will begin in the autumn. Point of sale materials are available.

Product info:
Novogen
Tel: 0845 603 1021

Price: £14.95
Pip code: 322-6594

Condom in a wallet promotes Aids day

Ahead of this year's World Aids Day on December 1, Condomania manufacturer Sexual Health Group has teamed up with the National AIDS Trust (NAT) to produce promotional condom wallets.

Available from NAT, the co-branded wallets contain a Condomania condom and instruction leaflet. The wallets are available to order in packs of 25 or 100.

A website has been launched, targeting young people and health professionals among others.

Product info:
Sexual Health Group
Tel: 01635 874393
www.worldaidsday.org

Clearblue predicts sales surge

TV advertising for the Clearblue Digital Pregnancy test began this week. The creative, which features a test stick held in a stream of liquid to represent urine, runs on terrestrial, satellite and digital channels until October 22.

Clearblue hopes that while some viewers will find the ad uncomfortable, most will find it refreshingly honest. The product's 'Pregnant' or 'Not Pregnant' digital display is demonstrated.

Product info:
Unipath
Tel: 0800 267 448

Happy shoppers seek Vicks

Customer satisfaction with Vicks First Defence nasal spray is high, reports manufacturer Procter and Gamble.

A recent survey found 77 per cent of users believed the product prevented them catching a cold and 90 per cent felt it met or exceeded their expectations. Two-thirds of buyers who were interested in repurchasing said they would go to another pharmacy if the product was not available.

Vicks First Defence claims to be the most successful new OTC product for colds in the 2005-06 season (source: IRI all outlets, 52 w/e June 2006).

Product info:
Procter and Gamble
Tel: 0800 597 4040

Lockets' love to hate campaign

Lockets is the subject of a £1 million TV spend this winter. The 'Proud sponsors of the British winter' campaign celebrates all the things we love to hate about the season, says manufacturer Masterfoods. The activity is expected to reach over 85 per cent of the UK's 25 to 44-year-olds.

The brand's share of the medicated market has grown by 13 per cent in the last two years (source: IRI total market, 3x52 w/e March 25, 2006).

Meanwhile, stablemate Tunes showed 25 per cent year on year growth following its repackaging in a flip top box, adds Masterfoods.

Lockets and Tunes are available in discounted parcel deals and a free two-tier unit is available to retailers.

Product info:
Masterfoods
Tel: 01753 550055

Energise your Xmas gifts

Battery brand Energizer has produced a battery package for the run up to Christmas. Batteries are displayed in a counter unit with two header card options and merchandising material. A consumer offer is available while retailers have the chance to win a plasma television set.

The unit includes 36 packs of Energizer Ultra+ AA batteries together with 14 free packs of AAA batteries worth £47.60. All packs contain four batteries.

According to Energizer, at least a third of batteries are sold between November and January, largely driven by battery-powered gifts.

Product info:
Energizer
Tel: 0845 601 0169

Products in brief

Berkeley Square range

A range of toiletries inspired by the roaring 20s and the Art Deco movement has been launched by the Berkeley Square Cosmetics Company. Comprising body lotion, shea butter soaps, bath and shower creams, hand cream, perfume sprays and gift sets, the range comes in four fragrances: fig and cherry, lavender, white tea and rose petal.
Price: from £5.95-£9.95; Berkeley Square Cosmetics Company; tel: 01923 213313.

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Steve Dunn *Group Managing Director, AAH*	**Delivering the new contract**
Simon Colebeck *Managing Director Numark*	**The future for independents**
Alastair Buxton *Head of NHS Services, PSNC*	**The new contract – lessons learned so far...**

October 16

Running from 11am

Dave Wendland *Vice President, Hamacher Resource Group*	**Enhancing the consumer shopping experience**
Kirit Patel *Chairman, Day Lewis Pharmacies*	**Effective Pharmacy Business Management**

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Fortuna offers magnetic attraction

Fortuna Healthcare has extended its range of supports with the launch of Neoprene Magnetic Supports.

Suitable for sporting and everyday activities, the range of one size supports is designed to enhance pain relief and comfort by promoting healing and providing firm, uniform compression, while allowing full movement of the joint or muscle, says Fortuna.

Made from neoprene rubber, the supports contain magnets to aid healing, claims the company.

Ankle, elbow, knee, wrist and back variants are available featuring Velcro fastenings.

Price: from £5.99

Product info:
Fortuna Healthcare
Tel: 020 8805 7805

Reality TV turn for NiQuitin CQ

Nick Heasman is the new face of advertising for the NiQuitin CQ NRT brand. The 31-year-old is attempting to stop smoking with the help of 4mg mint lozenges. He will report his progress via a video diary to feature in the TV ads, which are running until November 19, and in radio ads and online activity.

The previous 'reality quitting' campaign resulted in NiQuitin CQ's claiming its biggest ever share of the lozenge sector, reports GSK.

Product info:
GlaxoSmithKline
Tel: 0800 100 9997

Efamol helps kids concentrate

Efalex Chewies, a fish oil supplement for children, has been added to the Efamol range. Containing omega-3 and omega-6 long chain polyunsaturated fatty acids together with evening primrose oil, the supplement is said to help a child's concentration and maintain brain development.

Two of the wild berry flavoured capsules should be taken daily by children over three years of age, says Efamol.

• Efamol is investing in a research programme of more than a dozen studies looking at the benefits of omega-3 and omega-6 fatty acids for conditions such as dyslexia, anorexia and eczema. Previous research led to the presentation of two papers last month at the International Society for the Study of Fatty Acids and Lipid in Cairns, Australia. The papers related to the benefits of fish oils on dyslexic children and the benefits of evening primrose oil and fish oils on women of childbearing age.

Price: £4.99/30
Pip code: 317-7086

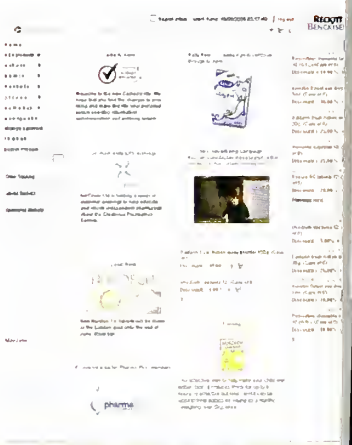
Product info:
Efamol
Tel: 0870 606 0128

Comedis signs up Numark

Numark has become the first company with wholesaling interests to sign up with online ordering portal Comedis. With Numark joining, the recently relaunched Comedis believes it can "offer an even more efficient business solution to all pharmacists".

Commenting, Simon Colebeck of Numark described the agreement as "a natural fit with our business".

Raj Patel, sales and marketing director at Comedis, added: "Having Numark on board is very encouraging and excellent news for the continued growth and strength of Comedis. The internet is the way forward for pharmacists looking for competitive advantages. The system not only offers 24/7 online ordering but also a wealth of information and training services to independent pharmacists."



Product info:
Comedis
Tel: 01536 481378
www.comedis.co.uk

Products in brief

Size matters

Superdrug is planning to introduce a super-size extra large condom to its own label range. The product is expected to go on sale next year.
Superdrug
Tel: 020 8684 7000.

Performance boost

Prelox is a new nutritional supplement from Pharma Nord. Containing pynogenol and L-arginine aspartate, the product improves male sexual performance and pleasure, claims the company. The recommended dosage is two tablets twice a day for the first two weeks then one tablet twice daily.

A trade launch offer of 'buy six get one free' is running and point of sale materials are available. Consumer advertising, including a TV campaign, will support the launch.
Price, pack size and Pip code: £29.75/60, 323-4606
Pharma Nord, tel: 0800 591 756.

Latex-free development

Durex is relaunching its Avanti Ultima condom next month. The new version will be the first condom to be made from syntheti polyisoprene polymer, says Durex. The product is designed for people with latex allergy. Benefits of polyisoprene include strength, softness and stretch, says Durex.
Prices: £3.80/2; £8.93/5
SSL International
Tel: 0870 122 2689.

Oral-B launches Sonic brush

The Oral-B Vitality Sonic powered toothbrush has been launched.

Described as an entry-level power brush, the product aims to encourage consumers to trade up from manual brushes. It removes plaque and stimulates the gums, says Oral-B.

Power brushes are used by less than 20 per cent of consumers in the UK, a figure Oral-B believes can be greatly increased.

The market is currently worth £70 million and growing at 11 per cent year on year (source: IRI value sales 52 w/e June 17, 2006).

TV advertising and PR activity for the new brush and the rest of the Vitality range supports the launch.

Price: £24.99

Product info:
Oral-B Laboratories
Tel: 01932 896000
www.oralb-vitality.co.uk

Products in brief

Meeting kids vits needs

Two products have been added to the Abidec range of licensed multivitamin drops for babies and young children.

Multivitamin Syrup with Omega 3 provides 100 per cent of the RDA for vitamins A, B_1, B_3, B_5, B_6, C, D and E plus 100mg omega-3. The lemon-flavoured product is designed for one to five year olds.

For children aged five to 12, Abidec Multivitamin Chewy Capsules with Omega 3 contain vitamins A, D, E and K, folic acid and fish oil. The capsules have an orange flavour.

Prices, pack sizes and Pip codes: syrup £4.99/150ml; capsules £4.99/30
Chefaro
Tel: 01480 421808

Happy 50th birthday Kleenex!

Kleenex for Men is celebrating its 50th anniversary this month with a range of consumer offers. Promotions will offer 50 per cent off and 50 per cent extra free on limited edition packs, which carry anecdotes from the last five decades.

Truck advertising is running and a promotional campaign is targeting the over 50s via special interest magazines and the Saga FM radio station. A website has been launched featuring old-fashioned images, a time-warp quiz and competitions.

Product info:
Kimberly-Clark
Tel: 01732 594000
www.kleenexformen.com

Temperature checker

The ThermaGuard temperature monitor is now available from ETI. Suitable for use on fridges, freezers and other temperature-sensitive areas, the device monitors temperature and power status. The user is alerted via a telephone call if the alarm settings are activated. It can also accept incoming calls to check readings.

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Price: £120 excluding VAT

Product info:
Electronic Temperature Instruments
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Products advertised on TV next week

Bassets Soft & Chewy Omega-3: GMTV, Sat
Bio-Oil: All areas except CTV, LWT, CAR, GMTV, Sat
Canesten Duo: All areas
Clearblue Digital Pregnancy test: All areas
Deep Heat patch: All areas except U, five
Full Marks: C4, five, GMTV, Sat
Hedrin: five, GMTV, Sat
Huggies Dry Nites, Little Walkers: All areas
Nicotinell: All areas except GMTV
TENA Lady Mini Magic & TENA pants: All areas
Voltarol Emulgel P: All areas except GMTV, Sat
PharmaSite for next week: Anadin – Windows, **Anadin** – In-store, **Allergan** – Dispensary
Pharmacy channel: DTECTA Probiotics, Solpadeine Migraine, Child Immunisation

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Products in brief

Reading matter

New editions of three titles in the Family Doctor series are available.

'Understanding Food and Nutrition' looks at the link between diet and health. 'Understanding Migraine and Other Headaches' enables readers to understand the causes of their headaches and control their symptoms. 'Understanding Diabetes' aims to give diabetics the confidence to be in control, says the publisher.

Price and Pip code: £4.75; 323-9985 (nutrition), 323-9977 (headaches), 323-0141 (diabetes)
Family Doctor Publications
Tel: 01202 668330.

Norfolk Lavender floats

Lavender and water lily is the latest fragrance launched by Norfolk Lavender. Five formats are available: body lotion, hand scrub, hand cream, crème hand wash and bath & shower crème.

The company has also redesigned its Lily of the Valley products, giving a "modernity" to the range.

Prices: from £5.95 to £8.95
Norfolk Lavender
Tel: 01485 570384.

Pampers flexes muscles

Baby-Dry Caterpillar Flex is the latest offering from Pampers. Said to offer better flexibility and guard against gaps and leaks, the nappies feature the brand's 'baby-dry' core system and will replace the existing Baby-Dry products.

Supporting the launch, a £3.4 million campaign is underway.
Procter & Gamble
Tel: 0191 297 5000.

Coty signs up Kylie

Australian pop star Kylie Minogue has signed an exclusive licensing deal with Coty to develop and market a line of fragrances and ancillary products.
Coty
Tel: 01233 656244.

The British Pharmaceutical Conference took place in Manchester earlier this week. In this issue we bring you some of the highlights including the C+D Practice Research Award and the minister's views on regulation

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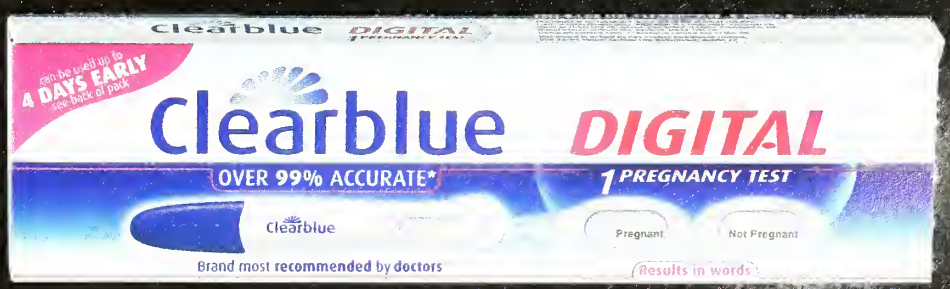

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Community pharmacy could face a workforce crisis

There was little comfort for community pharmacy in the news that morale in the profession is at a low ebb

Fiona Salvage

Community pharmacy could "potentially have a big problem on its hands" if employers do not tackle dissatisfaction amongst employees and especially relief pharmacists and locums, warned BPC practice chairwoman Karen Hassell in her inaugural lecture.

Out of all those working in community pharmacy, though, relief pharmacists, followed by locums, are the most dissatisfied. The roles of relief pharmacists and locums may need redefining by employers in the sector in order not to lose a vital sector of community pharmacy's workforce, on which it relies heavily, she suggested. This could be achieved by changing working practices, introducing more challenges and more responsbility, she said.

Areas of concern centre around lack of autonomy, lack of recognition for good work, a lack of opportunity to use their abilities, and variety in the job. "It is worrying," she said, "because the community pharmacy sector relies quite dramatically on the work of locum pharmacists as there are over 8,000 pharmacists working as locums in the community sector." Locums and relief pharmacists make up over 50 per cent of the community pharmacist workforce.

Research into levels of satisfaction among pharmacists shows those working in community pharmacy scored lowest in nine areas out of 10. On the whole, women pharmacists are more satisfied with their job than their male colleagues, except when questioned about physical working conditions.

When asked about their intention to change their working life, community pharmacists and locums scored higher than the average on their intention to leave the sector, change their working hours and leave the profession. Almost 24 per cent of the locums said they intended to leave altogether compared to 13.3 per cent of community pharmacists and 11.2 per cent of the profession as a whole. Overall, 15.5 per cent of pharmacists said they were "dissatisfied to some level or another with their job". This increased to nearly 19 per cent for community pharmacists and 20.5 per cent for locums. "The difference is significant," Dr Hassell said.

Dr Karen Hassell: worrying statistics on pharmacists' perceptions of their jobs

Community pharmacists who are non-store based consistently scored higher than those with other job titles. Owner pharmacists were the least satisfied with their remuneration and their working hours.

Despite this, pharmacists (4.81) do have a higher score than GPs (3.9) on identical job satisfaction surveys. Nevertheless, the profession does score below the national average (5.25) determined by the British Household Survey, which uses the same criteria. Dr Hassell says the evidence is not unequivocal, but it does suggest that there is relatively good overall job satisfaction. However, dissatisfaction levels do appear to be falling, but this is not conclusive as the studies cannot be directly compared.

She concluded by warning the audience that "the risks of ignoring the findings could be high", because there'll be a demotivated workforce, but also "a potential waste of education and training and resources". It will put "the professional agenda in jeopardy if you have a particularly demotivated and unhappy workforce", she said.

> The risks of ignoring the findings could be high because there'll be a demotivated workforce

David Pink: looking for an extended role

No future in dispensing only

Fiona Salvage

Pharmacy has no future in just dispensing medicines, claimed David Pink, of the Long-Term Conditions Alliance, at the BPC this week.

"We need to look at pharmacy having an extended role because just handing out medicines isn't going to hack it in the future," he claimed. Using his 80-year-old father as an example, he said: "He would be just as happy to order his medicines over the internet and have them delivered by post. If all pharmacy does is dispense medicines, he might as well be given a code number and a plastic card to be given entitlement to NHS access to the medicines, but without the inconvenience of the pharmacy as a physical location."

However, he thinks there is "huge potential for medicines and other advice to be made available in pharmacies, and the evidence we do have... shows that medicines are a major area of concern for people with long-term conditions and people don't feel they have ready access to interactive advice about their concerns."

He explained that his father thought getting help from the pharmacist about medications was "an excellent idea", having previously thought the pharmacy simply an added inconvenience after collecting a repeat prescription from the GP.

The other area where Mr Atkinson thinks there is a great opportunity for pharmacy is by allowing patients to personalise care and to maximise the benefits they obtain from their treatments.

Pharmacy, for people with long-term conditions, could offer a "gateway to a health service that beats the pants off existing services and I really think we need to move rapidly to that". However, he said that this should be done from the patients' perspective, and not according to what is currently convenient within contractual frameworks.

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C+D Practice Research Medal winner

The winner of this year's BPC Practice Research Award Medal, sponsored by C+D, is Rob Horne, Professor of Psychology in Healthcare

From pharmacy to psychology and back again: researching the psychology of medicines usage and implications for pharmacy practice.

Professor Rob Horne is the winner of this year's BPC Practice Research Award. His work has looked at medicines usage and applying scientific principles to explaining the medication-related behaviour of patients (adherence) and practitioners (prescribing).

This work has improved understanding of patient and physician perspectives of medicines and contributed to the development of theory and methodology. Its origins lie in a Pharmacy Enterprise Award made in 1992 allowing Prof Horne to study part-time for a PhD at Guys Medical School (now King's College London), while principal pharmacist at Brighton General Hospital.

Supervised by Professor John Weinman, the work was one of the first systematic investigations of the nature, determinants and effects of patients' beliefs about medicines across a range of chronic illnesses.

Rob Horne

My work is based on the premise that the rate-limiting step between the development of effective medicines and good health outcomes is behaviour: the behaviour of clinicians, in terms of prescribing, and the behaviour of patients, in terms of medicine-taking.

The practice of clinical pharmacy has always been essentially about influencing behaviour (of prescribers and patients). The original aim of clinical pharmacy was deceptively simple: 'to ensure that the right drug was received by the right patient in the right dose at the right time'. However, this meant a sea change in the way pharmacy was practised in hospitals, with pharmacists emerging from the basement onto the ward.

It represented a change from a product focus to a patient focus, with pharmacists becoming involved in discussions with clinicians and nurses about the appropriate therapy for individual patients. But often there was a forgotten figure in this: the patient.

Clinical pharmacy was practised on behalf of the patient but most of our efforts were targeted before the patient got the medicine. This remains a significant limitation. In affluent countries, such as the UK, most of the healthcare resources are targeted to the management of chronic diseases such as cardiovascular disease, diabetes and asthma. It is now recognised that good outcomes depend as much on self-management as on good medical care and for most of these conditions self-management hinges on the appropriate use of medicines.

In the UK, it has been estimated that over a third of prescribed medicines are not taken as directed. If we assume that the prescription was appropriate, this represents a loss to both the patient and the healthcare system. Moreover, effective solutions seemed elusive. There was a need for innovative approaches to the problem.

One of the main reasons for the lack of efficacy of previous adherence interventions is that they were not patient-centred enough. They generally adopted a 'one size fits all' approach and failed to consider both the practical and perceptual barriers to taking medication. This is problematic because non-adherence may be intentional as well as unintentional.

Unintentional non-adherence is the result of practical barriers such as problems of memory, dexterity, accessing prescriptions, cost, competing demands etc. Intentional non-adherence occurs when the patient decides not to take the medication prescribed in response to perceptual barriers such as beliefs, attitudes and expectations.

The main aim of my research programme was to investigate perceptual barriers to adherence. Previously research into medication adherence was hampered by a lack of valid and reliable methods for assessing the salient beliefs influencing patients' motivation to start and continue medication. To progress further we needed to identify the main themes underpinning peoples' beliefs about medicines and to find a valid and reliable way of quantifying them.

The first step was to see whether the commonly expressed beliefs about prescribed medicines could be summarised under simple core themes. My investigation of medication beliefs began by exploring the principal components underlying representations of prescribed medication, derived from interviews with patients and from the small number of published qualitative studies. This work, involving more than 4,000 patients from a range of chronic illnesses, suggested that people had 'common sense' beliefs, not just about specific medicines prescribed for a particular illness but also more general beliefs about pharmaceuticals as a whole. These general beliefs influence people's initial orientation towards prescribed medicines.

Further analyses showed that, although patients' ideas about medicines are often complex and diverse, many of the beliefs relating to specific prescribed medication could be grouped under two categories: perceptions of necessity or personal need for the treatment, and concerns about negative effects. Subsequent studies conducted in the UK and abroad showed that this simple necessity concerns framework explained non-adherence in a range of chronic illness samples including asthma, renal dialysis and post-transplantation, coronary heart disease, diabetes, HIV/AIDS, arthritis, inflammatory bowel disease and cancer as well as mental health problems such as depression and bipolar disorder.

In all of these studies non-adherence was related to the way in which patients judged their personal need for the prescribed medication relative to their concerns about the potential adverse effects of taking it.

Moreover, medication concerns were not just related to the experience of side effects but were also based on more abstract beliefs about the potential dangers of medicines such as accumulation, long-term effects and dependence.

The consistency of findings across types of illness demonstrated the 'necessity-concerns' framework could be used as a generic model for quantifying the key treatment beliefs influencing adherence.

This meant that the framework could potentially be used by practitioners to help them elicit salient patient perspectives and as a basis for discussion to facilitate optimal adherence to appropriately prescribed medication. However, to be of use in practice, we needed a better understanding of the origins of necessity beliefs and concerns.

I was also involved in the development of methods for assessing other relevant aspects of patients' experience of medicines including:

- Measures of their beliefs about illness.
- Satisfaction with information about medicines.
- Treatment empowerment.

These studies provided clear and consistent evidence that, although they were often not concordant with the medical view, patients' necessity beliefs and concerns were derived from 'common sense' beliefs about the illness and their interpretation of symptom experiences. They were also related to more general beliefs about medicines as a whole (social representations).

These findings were consistent with psychological theories of illness behaviour and resulted in the incorporation of medication beliefs into a wider theoretical model, the Leventhal self-regulatory theory.

plications for practice

dies of patient perspectives of their illness and atment produced consistent findings across ess samples. This showed that decisions about dication usage are often based on beliefs that, nough logically consistent from a common-se perspective, may be based on sconceptions and mistaken premises.

This work has coincided with a change in the geist in healthcare favouring greater patient olvement and choice – the concordance and dicines partnership initiatives are nifestations of this. The research findings have plications for how these ideals might be put into ctice and for how pharmacists might enhance ir 'near to patient' skills.

The findings and theoretical framework ived from the research described above formed basis for recent pilot intervention studies in hma and renal disease. Working with the vision of Psychology at the Institute of ychiatry, University of London, I have recently plied the models to understanding prescribing haviour and to explaining other treatment-ated behaviour such as attendance at rehabilitation classes following myocardial infarction and diabetic foot care.

In collaboration with the Department of Policy and Practice at the School of Pharmacy, University of London, I have applied this research in the development of a community pharmacy based intervention to identify medication-related problems and facilitate optimal adherence with promising results.

Applications have been used to develop communication skills packages for community pharmacy and in the teaching of communication skills for pharmacy students and graduates. This work is ongoing.

Further collaboration with DPPSOP and King's College London resulted in a recent scoping exercise for the NHS National Co-ordinating Centre for Service Delivery and Organisation. This provided a conceptual map of the areas of compliance, concordance and adherence and identified research priorities. A key finding was the need for the development of theory-based interventions tailored to the needs of individuals and informed by evidence of the antecedents of medication-taking behaviour.

I am looking forward to continuing to work with colleagues in pharmacy, medicine, psychology and other disciplines to continue the application of behavioural medicine in pharmacy to inform improvements in the quality of professional services designed to help patients get the best from medicines.

Many of the beliefs relating to specific prescribed medication could be grouped under two categories: perceptions of necessity or personal need for the treatment, and concerns about negative effects

Biography

Rob Horne is Professor of Behavioural Medicine and director of the new Centre for Behavioural Medicine at the School of Pharmacy, University of London, taking up the position this month.

Prof Horne is a registered pharmacist with a PhD in health psychology. He was a founding director of the Sussex NHS R&D Support Unit and Centre for Healthcare Research at the University of Brighton, where he was awarded a personal chair in Psychology in Healthcare in 2001. He has advised healthcare provider organisations in government, commercial and charitable sectors, within the UK and abroad.

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OV080

Patient studies reveal want they really want

atients are still unaware of what their community pharmacist can offer hem, warned Alison Blenkinsopp

ona Salvage

espite being one year into the new pharmacy ntract, recent research shows the general public unaware of the abilities of community harmacists and also of the new services they are oviding, including MURs, warned Alison enkinsopp of Keele University.

Professor Blenkinsopp quoted from the mmunity pharmacy medicines management udy, which found a low awareness among the blic of the pharmacist's role. Patients were aware they could approach a pharmacist or that harmacists had the knowledge to be able to help em with medication worries, she revealed.

Speaking at a session entitled "What do patients ant?" Professor Blenkinsopp said community harmacists need to use data to determine what tients want from them, which could include tient feedback questionnaires. Recent studies dicated longer opening hours and providing ating within the pharmacy as two key areas of tient concern.

Looking to the services that patients would like see offered by their pharmacy in the future, ofessor Blenkinsopp highlighted responses from e Liverpool public panel survey where 38 per ent of those questioned would like to get their ood pressure checked and 42 per cent their olesterol or blood sugar. More than 14 per cent ould like the pharmacist's help with weight loss.

Alison Blenkinsopp: public unaware of pharmacy services

Consumer Association focus groups have revealed 50 per cent of people say they use the same pharmacy, yet only one third of pharmacy users said they thought their pharmacist knew them and their medical history.

However, the CA focus groups raised concerns that pharmacists, although knowledgeable and highly skilled, were perhaps 'encroaching into GPs' territory', in the public's opinion.

Pharmacists back ethics code

lax Gosney

harmacists have expressed qualified backing for a rototype of the Royal Pharmaceutical Society's ew code of ethics.

The draft code offered a concise and onstructive set of guidelines on professional onduct, according to delegates at this week's ritish Pharmaceutical Conference in Manchester.

"I think what you've done is excellent. It's elevant, easy to read so I could hang it on my pharmacy wall for reference," commented a pharmacist after viewing an early version of the Society's revised code.

Other audience members also tentatively endorsed the draft code of ethics, which is being revised for further consultation with members later this year, according to RPSGB.

However, BPC attendees voiced concern that the code called on pharmacists to be responsible for working practices when many depended on third party support.

Pharmacists also criticised the RPSGB's decision to number its seven principles for pharmacists and pharmacy technicians. The move could mean people could consider rule seven less important than rule one, they claimed.

Lynsey Balmer, RPSGB's head of professional ethics, said: "I welcome your feedback, which is extremely valuable. We want to create a code which reflects the expectation of the patient, public and the profession. What we have at the moment is the bare bones of what the revised code will look like."

Revision of the new code of ethics is likely to be completed by the Society's annual general meeting in 2007, according to Ms Balmer.

The proposed code

The seven principles of the Society's draft code of ethics:

1. Make the care of patients your first concern.
2. Exercise your professional judgement in the interests of patients and the public.
3. Demonstrate respect for people.
4. Promote the rights of patients to participate in decisions about their care.
5. Maintain your professional knowledge and competence.
6. Be honest and trustworthy.
7. Take responsibility for your working practices.

Code of ethics is for all, says law professor

Max Gosney

Contractors must command their own "club rules" by seizing the initiative in the profession's consultation on its code of ethics, a law and ethics expert has claimed.

Pharmacists should seize a role in putting together the Royal Pharmaceutical Society's revised code, said Joy Wingfield, professor of law and ethics at Nottingham University.

"It's not the Society's code of ethics, it's yours. This is the rules of the club that you sign up to so it's very important you take an interest," she said.

Young pharmacists could swear an oath to the completed code, which is likely to be introduced in 2007, added Professor Wingfield. "Should we make the code more formal by considering a US style swearing in ceremony for our pharmacy graduates?" she said.

Overall, the revised code of ethics should set out the values: culture, standards, accountability and behaviour expected of pharmacists, said Professor Wingfield.

But the revised code is unlikely to clear many areas of confusion around professional conduct, according to Professor Wingfield. "Unfortunately if you put something down on paper and show it to five people then they'll come up with five different interpretations of what those words mean," she said.

Do we need a code of ethics?

Yes	No
• Useful guide for action.	• Code comes down to interpretation.
• Rules are public so pharmacists, technicians, health workers and public will know what to expect.	• Not applicable in all situations.
• Such rules are the result of much reasoning and analysis.	• Needs constant revision.

Improving GP and PCO communications

Pharmacists who want to offer new patient-focused services will need to sell their ideas to the local GPs and, for enhanced services, to the PCO. This article considers the challenges this brings and how these might be overcome

Paul Benson

GP communication

Relationships between GPs and pharmacists vary enormously: some have a very good working relationship, while others effectively have no relationship. The challenges in collaborating over new pharmacy services will therefore differ considerably.

Even where there is a good relationship, there can still be a lack of understanding by GPs of pharmacists' potential. Some are unsure of what pharmacists can offer beyond medicine supply services. There is certainly still confusion about the benefits of pharmacists' medicines use review services.

Let's assume a pharmacist has an idea for a new service and wants to approach the local practice to discuss the idea. The first contact in such cases is probably the practice manager. However, it could be that they are not receptive to the proposal and act as a barrier while the pharmacist believes that the GPs might be more positive. In such cases, negotiation skills will be needed to persuade the practice manager to let the case be presented. Alternatively, a way may have to be found of approaching the GPs informally.

It might be helpful to target a 'champion' GP to support the plans. However, while this may be a good starting point, any agreed service should not rely on one person. Some pharmacists have faced problems when they negotiated a service with doctors who subsequently left the practice. A written agreement will be needed so the service can carry on if personnel change.

Once the pharmacist has the GPs' attention, how do they sell their idea? It is essential to explain how the proposed service is expected to benefit patients. Where possible, value and outcome data from similar services elsewhere should be demonstrated – all the available evidence should be collected together to make the case. Evaluation of pharmacy services is still somewhat limited, but there is now published evidence of benefits of several services, such as anticoagulation monitoring, hypertension clinics, and smoking cessation.

In addition to expected patient benefits, it is useful to outline the potential benefits to the GP. For example, it could be emphasised that the proposed service will not involve duplication of effort but will complement the practice's services and reinforce their messages. It can also be helpful to point out any benefit in terms of helping GPs to attain their Quality and Outcomes Framework (QOF) points.

It may be possible to obtain agreement with the practice to try working together on the new service, perhaps in a collaborative project with other pharmacies. This collaboration might be set up via the LPC.

Before pharmacists approach GPs to discuss the service they would like to offer, it is important to ask what the GPs want from pharmacy. It is also useful to do some homework to see where the 'gaps' are so that an informed proposal can be presented that will be relevant to the practice. Information might also be picked up from customers and patients on what pharmacy services they would welcome. All this knowledge will put the pharmacist in a stronger negotiating position.

Another option is to consider approaching other agencies, such as specialist nurses, to support the new service. For example, respiratory and diabetes specialist nurses have a heavy workload and will often welcome help from pharmacy. In the respiratory area, a review of COPD patients – which would be covered by an MUR – could include advice on smoking cessation and inhaler technique. As well as patient benefit, this would help with the nurses' workload, and help GPs with their QOF points.

PCO communication

A pharmacist may be interested in undertaking one of the new enhanced pharmacy services, or an additional service for which there is no national specification, eg a weight management clinic. Who should they approach at the PCO about this, and at what stage?

Particularly for an additional service, it can take a long time to get a reply to a formal request as this is likely to have to go through various committees. So it is worth considering possible ways of speeding up the process.

One approach could be to try to obtain an informed view on the project's chance of success at an early stage – the pharmaceutical adviser/medicines management pharmacist would be a logical 'sounding board' for this. The pharmacy proposal could be put to them to gauge the PCO's

CASE STUDY

Paul Benson

One of the pharmacies in our group was approached by the PCT, along with other pharmacies in the area, to start a minor ailments service (MAS). As part of this, the PCT agreed to supply a lap-top computer for recording consultation reports. Initially there was some reluctance from the local GPs who saw no need for the service. However, once the MAS was underway, the doctors were enthusiastic as it became apparent how much of their time was being freed up because of the high number of inappropriate consultations they had been having.

In another case, an MAS was unsuccessful because the practice manager was unwilling to engage with the service and to train receptionist staff about pharmacy referrals. This highlights the importance of communication and negotiation with all practice staff – not just with the GPs – about new pharmacy services.

ossible response. If you are told the project is a efinite non-starter, perhaps because it does not fit with the PCO priorities and local delivery plans, ou will not have wasted time and effort in roducing detailed plans. On the other hand, a ore positive response to the proposal will crease confidence in moving on to the next stage, hich in the case of an additional service with no ational specification will be to think about reparing a business plan.

Preparing a business plan can be difficult r an independent pharmacist. Few of us ave had training for this and it can be a aunting process.

Pharmacists might choose to apply for an nhanced service on their own. Alternatively, they ould make a bid with other pharmacists on a cality (or cluster) basis, via the LPC. Sharing the reparatory work will be easier. The PCO is also kely to welcome a joint approach, as there is then no chance that it can be thought to be favouring a particular pharmacy. Working on a locality basis is the way PCOs are thinking about rolling out new services.

It is certainly worth obtaining the local GPs' approval for any proposed service – the proposal is likely to be looked on more favourably by the PCO if a number of surgeries have expressed interest in the service.

KEY ACTIONS

- Identify the key stakeholder – this varies from practice to practice and from PCO to PCO.
- Remember that PCOs often favour collaborative proposals from a group of pharmacists.
- Before approaching GPs with a proposal, find out what pharmacy services they would like.
- Collect evidence on how similar services elsewhere have benefited patients.
- Remember that other healthcare professionals, such as practice nurses, can be effective pharmacy advocates.

Sources of information

- NPA has resource packs on commissioning and enhanced services, and may be able to offer advice on business plans.
- PSNC website has resources on practice-based commissioning, including 'Pharmacy and PBC', a bulletin from Primary Care Contracting.
- CPPE runs workshops on negotiating skills and influencing skills.

About the author

Paul Benson
Paul Benson is professional services manager at PCT Healthcare Ltd, Manchester, a group of over 90 pharmacies, and a member of the Community Pharmacy Working Group.

Conclusion

In all such dealings with GPs and PCOs, good communication and negotiation skills are needed. These skills will also stand you in good stead when it comes to discussions about pharmacy involvement in the new plans for practice-based commissioning.

This article is supported by GlaxoSmithKline

Negotiating Skills

Opponents
High trust in you but low agreement with your proposal

Allies
High trust in you and high agreement with your proposal

Fence sitters
indifferent to you and your proposal

Adversaries
Low trust in you and low agreement with your proposal

Bedfellows
Low trust in you but high agreement with your proposal

The first step in negotiation is planning and a fundamental part of this is to identify and analyse the stakeholders. Negotiation theory divides stakeholders into five different groups, each of which will require a different strategy when lobbying. It can be useful to focus attention on "opponents" – their view on your proposal needs clarification. These people trust you and they may know something you don't.

Reference: Nutt PC, Backoff RW. Organizational transformation. J Management Inquiry 1997;6:308.

Rio de Janeiro, which played host to the annual UniChem convention from September 2 to 9

'Engage' or miss out on future success

Speaking at the UniChem conference in Rio de Janeiro, Brazil, managing director David Coles urged delegates to take advantage of opportunities

Gary Paragpuri

A future vision of more pharmacy-centric healthcare will fail to materialise unless pharmacists make the most of the opportunities available today, UniChem's managing director has warned.

Pharmacy's future was "very positive" but the profession needed to show a "collective ability" to make it happen, David Coles told delegates at this week's UniChem conference in Rio de Janeiro, Brazil.

Pharmacists needed to build credibility now by making their premises and staff ready for new services, by maximising revenue from medicines use reviews, and by developing IT systems, he suggested.

"If you are doing a lot to support the new pharmacy contract at local level, you will gain the credibility to influence others and help to create the vision," he told delegates in his opening address.

However, pharmacists' commitment was being frustrated by events outside their control, he admitted. This included patchy PCT commissioning and funding of services; a central government that on the one hand sought to encourage investment by pharmacists, while promoting competition; and continuing delays around IT.

However, if pharmacists focused on delivering in the areas within their control, they would have a "strong base to push [their] influence on [those] factors beyond [their] control", Mr Coles added.

David Coles: pharmacists are frustrated

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Views from the home nations

Keith Ridge, England's chief pharmaceutical officer, on:
NHS debt The NHS is in a period of change but the government is "committed to achieving financial balance". Pharmacy needs to plan how it can be "in the front of the queue".

Practice based commissioning Pharmacists should read the Primary Care Contracting bulletin on PbC, which will be the cornerstone of commissioning. "It is up to pharmacists to make the most of these opportunities."

Independent prescribing It's "fantastic" for pharmacists to have prescribing rights. The Royal Pharmaceutical Society's Council has signed off the curriculum for independent prescribing and the first pharmacist independent prescribers are expected to qualify early next year. Pharmacists do however need access to patient records.

Control of entry Don't underestimate its "complexity". It is a "cross-government issue".

Pharmacy's role in the future "The Department does recognise the value of pharmacy" but pharmacists need to be "knocking on the door at every level and that includes PSNC knocking on the door nationally".

Bill Scott, Scotland's chief pharmaceutical officer, on:
The new contract's capitation payments The SEHD is working with SPGC to develop capitation payments for the chronic medication service, moving pharmacists' focus away from volume and more to patient-centred services.

Control of entry The SEHD is not "against the ethos" of improving access to pharmaceutical services but ministers believe the NHS should have the ability to plan services. Every health board now has to identify unmet pharmaceutical need and come up with a solution to address that need.

Why is Scotland's contract different from England's? The contract was based on pilot studies in Scotland and evolved through discussions.

Will future reimbursement be based on capitation or will there be some purchase profits? It will be mainly capitation based but as long as community pharmacy is involved in purchasing medicines for the NHS, there will always be an element of retained purchase profits.

Independent prescribing The minor ailment scheme is "effectively" independent prescribing by pharmacists. Independent prescribing will allow the scope of the MAS to be extended. Prescribing helps pharmacists develop pharmaceutical care for patients and, as IT and robotics develop, "traditional pharmacy practice will atrophy". Future pharmacy practice will incorporate prescribing and pharmacists will become "pharmacotherapists".

IT fundamental building block for pharmacy

Benefits from IT include patient safety and cost savings, conference hears

Simon Driver in the 'Mastermind' chair answers questions on IT asked by Anthony Roberts

Gary Paragpuri

Technology has become a fundamental requirement for pharmacists looking to run their business – both over the counter and NHS – more efficiently, UniChem's IT director believes.

Not only does IT deliver patient safety and customer service functions, it underpins the move to provide essential, advanced and enhanced services in England and Scotland, Anthony Roberts told conference delegates.

UniChem IT solutions

Broadband UniChem's broadband ordering service is fully integrated with NexPhase and Pharmacy Manager and costs less each month than current monthly dial-up spend. N3 broadband link will allow pharmacists in the future to get more stock information and electronic delivery notes.

Electronic invoicing This gives pharmacists access to invoices, credits and statements at any time. UniChem is approved by the Inland Revenue to hold invoices online, which mean pharmacists do not have to store invoices. The system offers a search function and can provide archive of invoices on CD.

Pharmacy store web builder This allows pharmacists to upload products via broadband link to sell them online. The website can be tailored to an individual pharmacy.

In addition, front of shop IT solutions such as EposS (electronic point of sale) can help pharmacists improve margins and plan for the future, Mr Roberts said. He estimated that a pharmacy with over £50,000 of OTC sales could improve its margin by up to 5 per cent.

He said UniChem was planning on integrating an EposS system with Cegedim-Rx's Pharmacy Manager and NexPhase. This will free pharmacist from the dispensary bench, he said, by giving them a single point of ordering, integrated stock control and access to PMR records at the counter.

Urging pharmacists to embrace IT, Mr Roberts added: "When every UK pharmacy has IT systems and connectivity which allow it to participate in the digital world, I think the pace of integration and automation will quicken even further and we should not be afraid of this."

Pharmacy use of technology

Where manufacturers supply certain drugs, such as IVF medicines, either direct to patients or via hospitals only, IT can be used to ensure the traditional community pharmacy supply route is not bypassed.

An IT link between the supplier, wholesaler, hospital and pharmacy would allow a shared care package to be set up. This means that, for example, after initial supply by the hospital, the pharmacy can take over responsibility for supply and ongoing medicine use review.

In this model, the pharmacy receives payment for dispensing and for providing the ongoing service.

A quick guide to EPS by Cegedim Rx managing director Simon Driver

EPS release 1

- Patient visits GP who uses an accredited system which incorporates EPS release 1.
- GP enters prescription details onto system. An electronic message containing prescription details is sent to the EPS via the doctor's N3 connection.
- A paper FP10 is printed. It is identical to any other prescription except for the barcode on the right, which is a coded match of the electronic prescription sent to the EPS. The GP signs the FP10 and hands it to patient.
- In release 1, the paper FP10 remains the legal entity.
- Patient takes FP10 to pharmacy.
- If pharmacy has not implemented EPS release 1, it can dispense FP10 as usual.
- If pharmacy has EPS release 1 in place, pharmacist scans barcode on FP10 using barcode scanner.
- Electronic prescription is retrieved from spine via pharmacy's N3 connection, automatically populating relevant fields of PMR system.
- Pharmacist then selects appropriate drug to fulfil Rx, prints label and prepares medicine.
- Confirmation of medicine dispensed sent to EPS.
- At end of the month, paper FP10s are sent as usual to reimbursement agency.

EPS release 2

- Looks virtually the same as release 1 but some key changes.
- Now optional for GP to give patient a piece of paper (token).
- Patients now have option to nominate pharmacy to send prescription to (patients expected to have option to change nomination at any time).
- GP has ability to apply digital signature to the electronic prescription, making it the legal entity and not the paper FP10 form.
- Patient has right to request paper prescription if they wish. This paper version, referred to as the prescription 'token', will look almost identical to the FP10 used in release 1, except it will not be signed by GP.
- Traditional hand-signed prescriptions will continue for medicines not within scope of EPS.
- Release 2 allows pharmacists to send reimbursement claim electronically to relevant agency. But no mention yet of faster reimbursement.
- A pharmacy that does not have a smartcard on the premises will not be able to operate.

More coverage of the convention will appear next week ›

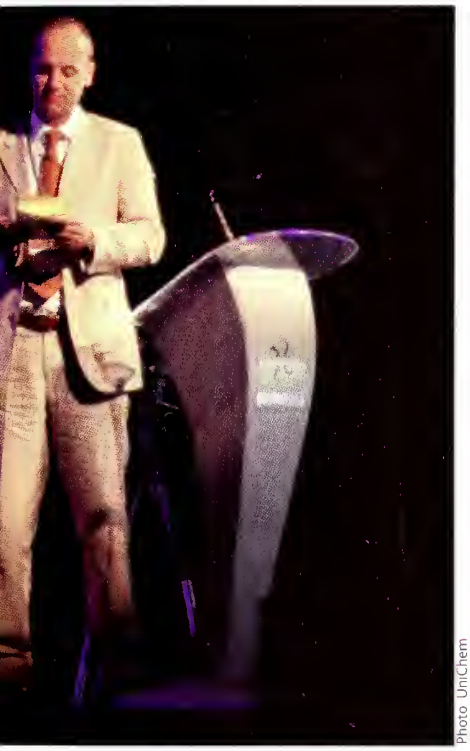

Photo UniChem

Boots joins the NPA

Membership demonstrates 'commitment' following merger

Delegates in Rio were told that Boots The Chemists has joined the National Pharmacy Association.

The decision follows the merger this summer of Boots with the Alliance UniChem group. The latter's UK retail division, Alliance Pharmacy, was already an NPA member.

Describing the move as "excellent news" for independent pharmacy, David Coles, UniChem managing director, said the decision was evidence that the newly merged Alliance Boots was "absolutely committed to a successful future for community pharmacy at large and plans to be an integral part of the wider pharmacy community".

Similarly, the NPA said the decision illustrated a "commitment to a cohesive community pharmacy sector".

It added: "One of the mistakes pharmacy has made repeatedly in the past is to present to opinion formers a fragmented and divided view. This seriously weakens pharmacy's position.

"This will not be measured by the number of bodies purporting to represent the sector but the collectiveness of the message."

Cardiff pharmacist Matthew Price gave a presentation on pharmacy in Wales

T in practice

ımes Allan, community pharmacist and hairman of UniChem's Scottish customer orum, on Scotland's electronic minor lment service:

The electronic minor ailment service (eMAS) is ne of the four elements of Scotland's new harmacy contract.

Delivery, management and reimbursement of MAS is electronically carried out.

Eligible patients register with pharmacy for MAS. Registration generates an electronic essage which triggers remuneration payment.

Following registration, pharmacists can choose o (i) prescribe and dispense a medication, (ii) efer to GP, or (iii) consult with patient only.

Record of registration and any consultations is corded in the PMR system. Data is also ansferred to Central Patient Registration System.

Funding is via banded capitation dependent n the number of patients registered at the end f the month.

Registration is active for one year but lapses if o activity takes place in that period.

Any consultation extends registration for a urther 12 months.

Patient can choose to register with another harmacy but Central Patient Registration ystem will terminate previous registration.

Has proved popular with patients – 450,000 atient registrations so far, almost 10 per cent of ne population.

1,172 pharmacies in Scotland and all but two re registering patients electronically.

Talking their language

Tourists bring with them their own expectations of pharmacy services, even in a village on Scotland's west coast

Jeannette Smith

Summer has gone all of a sudden, and with it the tourist flood is drying to a trickle. The other day a pair of German women, having exchanged the usual courtesies, stood looking for a while around the shelves. "What a nice little shop," one said. "It must be pleasant to work in a place like this – no hurry, no hassle, no problems."

I tried not to laugh, but I came out with such an audible snort that I had to explain myself. "You should have been here earlier in the week." If you know anything about German grammar you can appreciate my pride at finding the right parts of the verbs in the right order without thinking.

We had begun with an elderly coach passenger who had slipped on the step into the bus. Somebody, possibly the driver, had wrapped a loose bandage around her shin. When we saw her, the bloody bandage had fallen down round her ankle. Under the bandage, the same somebody had stuck on a couple of bits of plaster. I didn't dare to touch the plasters. In between them was a loose flap of skin oozing blood. We covered the mess with a large piece of Melolin and told her to report the accident to the hotel so that she could have the leg seen to properly.

Five minutes later her sister came in wanting to buy another dressing for the morning. We just had to hope we really had persuaded her sister that our first aid had been a temporary measure to last until the coach reached its overnight stop.

After her came an Italian doctor in search of an injection of cephalexin. Sometimes I think that we ought to have a translation of the medicine and ethics guide pinned up in a prominent place, opened at the page where it says that "the word 'doctor' means a doctor registered in the UK with the GMC". It's no good having an identity card proving that its holder is registered to practice in one of the EU countries. He can't issue a prescription, private or not. In any case, I have never seen a cephalexin injection. He was amazed. GPs from mainland Europe are often amazed by our reliance on oral drugs. Fortunately he did have his own supply of co-amoxiclav, so we parted amicably enough, although I didn't quite gather which piece of his son's anatomy was infected.

Half an hour later I'd have been grateful for his presence when a couple came who spoke no English at all. I can understand Italian fairly well but I have forgotten how to speak it properly. "Voltaren," they demanded, and produced a syringe big enough to treat a horse. As far as I could gather they wanted either a syringe or some 75mg tablets. One of them was suffering from renal calculi, a useful word which sounds the same in many languages. Since the surgery was open we pointed them in the right direction and hoped for the best.

When they went back up the road accompanied by the policeman, I realised that I still had some work to do so I shot out after them and explained to the doctor's wife as much of their story as I had understood. She produced the regulation form to allow them to treat a temporary resident, and we showed them to the waiting room. At that, they took fright, rushed over to the desk and tore up the completed form – they didn't want a consultation, just their Voltaren. If they hadn't been an apparently bewildered elderly couple, we'd have been suspicious of their motive for wanting the drug in the first place.

I have two questions. How on earth can so many people come on holiday without their regulation medication? Once we met a man who had forgotten his MST. The second question is for tour companies. Do they have nobody in their coaches to avoid a woman with a mangled shin being tipped out to hobble around the street till it's time to go? Do they not carry an interpreter to help their passengers who can't speak English? Now and again we do have a tour guide coming in with their customers, but the coach companies appear to be trying to cut costs at the expense of comfort and convenience. What's the good of a bit of local colour at the coach park, in the shape of a piper, if the customers are left to get on with it as best they can?

It's no good having an identity card proving that its holder is registered to practice in one of the EU countries

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Legal Category: P. **MRRP:** 100ml: £3.59. 150ml: £4.59 **Nurofen for Children:** PL 00327/0085. **Date of preparation:** June 2005.

References:

1. Sidler *et al.* A double-blind comparison of ibuprofen and paracetamol in juvenile pyrexia. *Br J Clin Pract* 1990 **44**(suppl70):22–25.
2. Kelley MT *et al. Clin Pharmacol Ther* 1992, **52**:181–186.

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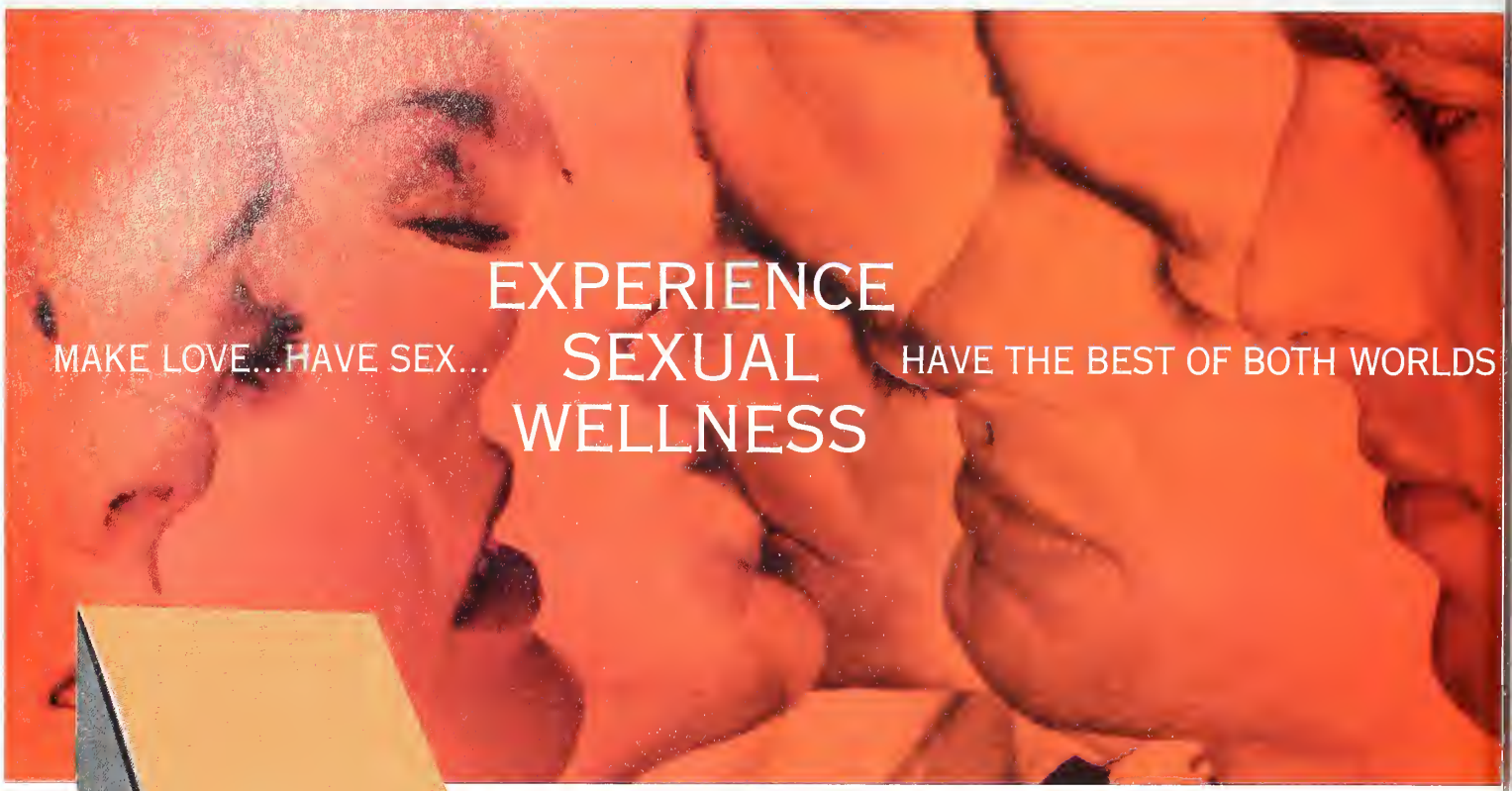

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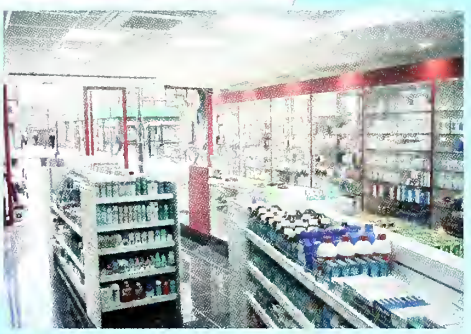

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Pharmacists race for charity

Pharmacists have been putting on their running shoes for charity in recent months, including a team from Bailey & Garrett, a Burnley pharmacy, and Elspeth Davies, a pharmacist at Proctors Chemists in Heathfield, East Sussex.

All 11 of the Bailey & Garrett team completed the 5km Race for Life in support of Cancer Research UK, raising more than £1,200.

"The event was a great team-building exercise, as well as a rewarding one," said Carole Livesey (pictured laughing), trainee technician.

Numark provided the team with T-shirts as well as sponsoring them to boost the final amount they raised.

Elspeth Davies, who has been a pharmacist for 30 years, joined a team of runners at the London 10km race, which raised about £2,000 for Talking Newspapers, a charity that produces audio tapes, CDs and internet files for blind and partially sighted people. Ms Davies said she collected around £200 through friends and customers.

Above: Bailey & Garrett's team members: (back, left to right: Sharon Pruskin, Natalie Livesey and Linda Davis. Front: Emma-Leigh Rowley, Carole Livesey, Sarah Holmes, Catherin McCallion and Tracey Rowley Left: Elspeth Davies, second from right, who ran for the Talking Newspapers charity

Appointments

Penn Pharmaceutical Services has appointed Damian Gant as project manager. He joins from Brecon Pharmaceuticals where he was project manager in the clinical trial supply division.

AAH Pharmaceuticals has made two key appointments to its Vantage professional services team. Sara Mudhar, below right, has joined as professional services development manager, while Hanie Aghamohammad, below left, joins Vantage Health Watch as Scotland and North England business manager.

Only exercise will beat orange peel thighs

Although thousands of pounds are spent each year on creams, machines and now clothes to shift cellulite, leading cosmetic surgeons have said that losing weight is not necessarily the answer.

The American Society of Plastic Surgeons' journal, Plastic and Reconstructive Surgery, has published details of a study that found weight loss improved cellulite, but for a few who started off slimmer than others in the study it made it worse.

Nevertheless, the fashion and beauty industry continues to claim it has found a cure for dimpled thighs. The Miss Sixty clothing company, for example, has introduced a range of jeans, trousers and skirts containing a serum called Skintex, which it claims can smooth away cellulite.

The British Association of Aesthetic Plastic Surgeons says going to the gym three times a week might have the same effect. Damn!

A team of Superdrug pharmacists, from the left, Joanna Kilkelly, Emma Corry, Diana Ghani and Anne Clark, provided more than 200 music fans at T in the Park in Kinross, Scotland with a skin testing service that recommended the most appropriate SPF factor sun cream for their skin type. The machine tailored the best recommendation according to surrounding conditions and the length of time spent out in the sun. Diana Ghani carried out beauty treatments and makeovers. The services were free and raised awareness of the dangers of unprotected exposure to the sun

Cambridge Counterpart winner

Bernice O'Reilly from NCC, Plainmoor Pharmacy in Babbacombe, Torquay was July's winner of the C+D Cambridge Counterpart draw sponsored by Wyeth. She has been at the pharmacy for just 12 months and was pleasantly surprised to be a winner. She was presented with her prize of a bottle of Champagne by Phil Davis, Wyeth's territory manager. Her hobbies include making and decorating cakes, especially wedding cakes with decorative icing.

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